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1969
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SOCIAL SECURITY AND WELFARE PROPOSALS

HEARINGS
BEFORE THE
COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES
NINETY-FIRST CONGRESS
FIRST SESSION
ON THE
SUBJECT OF SOCIAL SECURITY AND WELFARE
PROPOSALS

OCTOBER 15, 16, 21, 22, 23, 24, 27, 28, 30, 31, NOVEMBER 3, 4, 5,
6, 7, 10, 12, AND 13, 1969

Part 5 of 7
(November 3, 4, 5, and 6, 1969)

Printed for the use of the Committee on Ways and Means



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LAW 13.5

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U.S. GOVERNMENT PRINTING OFFICE

WASHINGTON : 1970

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SOCIAL SECURITY AND WELFARE PROPOSALS

MONDAY, NOVEMBER 3, 1969

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The committee met at 10 a.m., pursuant to notice, in the committee room, Longworth House Office Building, Hon. James A. Burke presiding.

Mr. BURKE. The committee will be in order.

Our first witness is the Honorable Seymour Halpern from the State of New York. Please identify yourself for the sake of the record and you may proceed.

STATEMENT OF HON. SEYMOUR HALPERN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. HALPERN. Mr. Chairman, these hearings before the Ways and Means Committee on proposals to amend the Social Security Act are long overdue recognition that the retirement benefits accorded the Nation's senior citizens are totally inadequate to meet the minimum needs of life.

After a lifetime of contributing to the productivity of America, retirees have a right to expect to live free of hardship and despair. Social security benefits must be realistically aligned to reflect today's cost of living and built-in provision must be made to protect retirees against future inflationary increases in living standards.

Indeed, social security benefits are clearly inadequate to offset the inflationary pinch on retirees living on fixed incomes. The result of our grossly unfair law is to consign many honorable, hard-working Americans to the poorhouse when they become old.

Three out of 10 people over age 65 are living in poverty, in contrast to one in nine younger people considered poor. And the gap is widening: Retirees have less than half of the buying power of those working.

A realistic reappraisal of social security is needed then, building into the system automatic benefit increases which will "depoliticize" old-age insurance.

Retirees have a right to live their declining years in reasonable comfort, yet current benefits are as slight as \$44 monthly or even less in some cases—hardly very reassuring for someone who has worked all his life.

I urge the committee to give utmost consideration to H.R. 14149, which I cosponsored, which will increase cash payments by 50 percent. It would provide a \$103 monthly minimum in three steps over the next 4 years.

Let me emphasize that retirees are not looking for a handout. They have worked steadily and faithfully for a great many years, or they wouldn't be on pensions. They deserve to have some protection against the inflation that is cruelly diluting their only sustenance.

Even a 50-percent increase would provide a very modest living level for today's impoverished retirees. With this increase, a retiree would average no more than \$1,764 yearly and elderly couples would average about \$2,970 annually.

Under the bill I cosponsor, the present minimum monthly benefit of \$55 would increase to \$103 by 1974, with an immediate 15-percent social security boost to \$80 in January 1970. Other provisions of the bill include:

Benefits would be adjusted automatically every 2 years for each 1-percent increase in the cost of living starting in 1975.

Widows would get 100 percent of their deceased spouse's benefit at age 65, instead of today's fragmented 87½ percent. And the age 50 limit for qualifying disabled widows is eliminated, providing them with regular benefits.

The elderly can earn \$1,800 yearly without reduced benefits; now the ceiling is \$1,680. And in any 1 month earnings can rise \$10 to \$150 without loss of benefits.

Reduce the waiting period for disability benefits from 6 to 3 months and liberalize definition of disability.

Extend medicare health insurance coverage to the disabled and include prescription drugs in coverage for the elderly.

The cost for these increases will be met by raising the contribution base to \$15,000 a year, which is equivalent to the \$3,000 base used when the program was started in 1935. Social security tax increases will be one-tenth of a percent for employees and employers. After 2 years, the Federal Government would start contributing nearly a third of the cost.

The need for a significant and immediate social security increase is dramatized by the Consumer Price Index for September 1969—a 5.8-percent increase over a year ago. The major victims of this relentless upward trend are the elderly who must subsist on small fixed retirement incomes. Medical costs, which impose a particularly heavy burden on the elderly, increased at an even faster rate during this same period, by 7.7 percent.

The Department of Labor has just released three typical budgets for retired couples, which describe the kind of standard of living to be expected for a given income in the spring of 1969. The Department reports that rising prices between spring 1967, the last period for which other budgets had been prepared, and spring 1969, added about 9 percent "to the cost of goods and services required to sustain the retired couples."

The cost estimates of the retired couple's budget are for an urban family of two persons—a husband age 65 or over and his wife—who are presumed to be self-supporting and living independently. The budgets permit the couple to maintain its health and well-being and to participate in community activities. The three budgets are divided into lower, intermediate, and high. Couples living under the lower budget can expect average total costs of \$2,671. The intermediate budget cost is \$3,857 and the higher budget totals \$6,039. The lower budget assumes a small proportion of homeownership while the inter-

mediate budget assumes 65 percent of homeownership and the higher budget assumes that 75 percent of the couples own their homes.

Consumption items such as housing, food, transportation, clothing, and medical care totalled \$2,556 in the lower budget, \$3,626 in the intermediate budget, and \$5,335 in the higher budget. While representing a comfortable standard of living the higher budget definitely is not an affluent budget. Obviously, an income of \$5,000 would require a tight budget.

I would also point out that the elderly pay taxes that may seem small compared to that paid by an employed person, but to the elderly man trying to support his wife, this tax added to his other expenses may create an economic crisis. The retiree is also faced with rising taxes at the State and local level. For those who own their homes, property taxes have been rising steadily. In addition, sales taxes are often imposed on food and nonprescription drugs.

The elderly should not have to be satisfied with a hand-to-mouth existence. These people have worked hard all their lives and deserve to look forward in their final years to a time of dignity and reward not to one of foreboding and degradation.

Mr. BURKE. Does that complete your statement? Are there any questions? If not, we appreciate your coming to us today.

Mr. HALPERN. Thank you.

Mr. BURKE. Congressman Robert W. Kastenmeier. We are pleased to have you with us today and you may come forward and proceed as you wish.

STATEMENT OF HON. ROBERT W. KASTENMEIER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

Mr. KASTENMEIER. Mr. Chairman, I appreciate your giving me an opportunity to present your committee with a statement on the proposed amendments to the Social Security Act, including my bill, H.R. 14152.

These hearings come at a time when an increasing number of our senior citizens live in real poverty. The large proportion of these older citizens were active and productive workers in their younger years and they invested part of their earnings in the social security system, with the promise of an income when they retired. Yet, with the rising cost of living, the elderly, many of whom have no income in addition to their social security payments, simply cannot meet the cost of basic goods and services and taxes.

The mail I have received reflects their plight and I am certain each member of this committee and most, if not all, of our colleagues have heard from social security beneficiaries like the couple who told me the monthly social security check they receive is \$75.60. To economize on real estate taxes and other expenses, they sold their home and moved to an old schoolhouse in a small community. Now their property taxes have risen 450 percent at the same time they must try to pay for such basic necessities as food and drugs. Or the widow with a monthly benefit of \$51 who has budgeted as closely as possible to stretch her small income and resorts to such economies as using only a Christmas tree bulb for light when she is alone.

These examples may seem extreme, but I am convinced they are not, for the Social Security Administration tells us that the average cash

benefit for a retired worker is \$100 monthly, with elderly couples receiving \$168 and aged widows \$87 on the average.

I doubt that any of us would seriously contemplate trying to exist on such a small basic monthly income and yet many of our retired citizens must do so. It is a sad and bitter irony that our modern society, which has witnessed the benefits of medical breakthroughs that substantially prolong human life, has not made adequate provision for our elderly citizens so they can live in dignity and enjoy their retirement.

I believe we now must acknowledge the fact that social security payments are relied upon by many of our elderly as their prime income and that the present level of benefits simply is not enough.

My conviction that we must meet our obligation to our elderly citizens led me to propose a 25-percent across-the-board increase in benefits. While I realize this may seem quite high at first glance, the steadily rising cost of living and our failure to provide adequate benefit raises in the past make a substantial hike necessary now.

In addition, my bill, H.R. 14152, would double the minimum primary benefit by raising the present minimum of \$55 a month for an individual to a much more realistic \$110. The minimum amount for a retired couple also would increase from \$82.50 to \$165 monthly.

My proposal also would raise the earnings limitation, add prescription drugs to the medicare program, extend medicare coverage to those receiving social security disability benefits, and provide for automatic cost-of-living benefit increases in the future.

The present \$1,680 limitation on earnings is much too low with the result that it penalizes senior citizens who wish to work to supplement their incomes and it denies our Nation's economy the benefit of the experience and productivity of these older workers.

I feel the present earnings limitation should be raised to at least \$2,400 so that a worker can keep the first \$200 he earns each month as well as \$1 of every \$2 from \$2,400 to \$3,600.

Since drug costs now are a major expense for elderly citizens, I propose that the cost of prescription drugs be added to the medicare program. Although persons 65 and over constitute only 10 percent of our population, they account for 20 percent of our \$3.5 billion consumption of prescription drugs—an expenditure many can ill afford, especially in view of the escalating cost of this and other medical care items.

Under my bill, a committee would be established to compile a list of necessary drugs which would be disseminated annually to physicians and druggists. The list would include each drug or biological by generic and brand names, with prices, in an effort to make available information on the various names and prices for each drug. Reimbursement under medicare would be based on the lowest priced generic or brand name drug on the market, consistent with Federal Food and Drug Administration standards.

I also support extending medicare coverage to those receiving Social Security disability benefits. Those severely disabled citizens, like the elderly, have greatly reduced incomes and high health costs and they frequently cannot obtain adequate private health insurance at a reasonable price. The need for this expansion of the medicare program has been widely recognized and was recommended by the outgoing Secretary of Health, Education, and Welfare, Wilbur Cohen, last January.

Proposals to authorize automatic cost-of-living increases in the future have received substantial support, including the backing of the President. I firmly agree that we need to assure our social security beneficiaries that their benefits will raise as prices increase, rather than lagging behind as they have while the cost of living has soared by 8.7 percent since the last benefit raise in February 1968. Several years ago we authorized an automatic cost-of-living increase for civil service annuitants. My bill establishes the same system for those receiving social security benefits so that their payments would be increased by the amount the cost-of-living index has risen whenever this is more than 3 percent. Unlike the administration's proposal and several others I have seen, this increase mechanism would be triggered each time the cost of living has risen at least 3 percent.

The President's recommendation of a 10-percent increase, effective in March 1970, is not totally responsive to the needs of our elderly citizens and would not constitute a real increase at all. Due to inflation and rising taxes, it would represent a loss in actual purchasing power by next March. In addition, a raise in the earnings limitation from \$1,680 to \$1,800 annually is too small and token an increase to be of any real benefit to senior citizens who wish to work or find it necessary to do so to supplement their incomes.

However, he has proposed several improvements in our social security system which I feel have considerable merit. Among these is his recommendation for higher benefits for widows and widowers who do not begin receiving payments until age 65. Many widows and widowers find they cannot maintain their standard of living when their spouse dies, particularly since many of their costs, such as rent, property taxes, and utilities, remain virtually constant while their benefit is reduced to 82½ percent of the spouse's former payment—a cutback of close to 50 percent of the full benefit and a half they had been receiving. I feel a good case can be made for providing a higher benefit for these widows and widowers, perhaps through the device the President has suggested which would increase the benefit entitlement of those who wait past 62 to begin receiving payments.

Other administration suggestions I favor are the proposals for:

Full benefits for the entire calendar year in which a person reaches age 62—regardless of his earnings in the months before he becomes 72.

Benefits for children who become totally disabled before age 22—rather than the present age limit of 18.

Benefits for the aged dependent parents of retired and disabled workers—in addition to the present coverage for the dependent parents of workers who have died.

Equalization of the treatment of men and women in the computation of average monthly earnings—the average on which monthly benefits are based. (This change would lower, to the year in which a man becomes 62 instead of 65, the ending point of the period of years used in calculating a man's average monthly earnings, thus making the ending point for men and women the same and, in many cases, raising the earnings average and benefit entitlement of men and their families.)

Some may challenge the 25-percent increase I have recommended on the basis of its cost. I believe, however, that we must put the

welfare of our social security beneficiaries ahead of the fixed concept that the social security system must be self-supporting. At the same time, we must recognize the burden social security taxes place on many workers and avoid an undue burden on them.

As a result, I have proposed financing my bill by an increase in the amount of taxable earnings, from \$7,800 to \$9,000 with no raise in the present contribution rate. These additional contributions would be supplemented by general tax revenues. The closing of tax loopholes, together with the administration's announcement it contemplates a budget surplus this fiscal year and the prospect of reduced military spending as we terminate our involvement in Vietnam should provide the Treasury with more than enough general tax funds to cover the cost of higher benefits.

The crisis our older citizens are facing makes a substantial benefit hike imperative now. Consequently, I hope this committee will, after careful consideration of the needs of our social security beneficiaries, act promptly to provide the level of benefit increases and other amendments which are necessary to enable our elderly to meet their basic expenses and live in dignity.

Mr. BURKE. Thank you for your statement to us here today. We appreciate your coming to the committee.

Mr. KASTENMEIER. Thank you, sir.

Mr. BURKE. Our next witness is the Honorable Henry B. Gonzalez from the State of Texas. Mr. Gonzalez, please step forward and we will be glad to hear your testimony.

STATEMENT OF HON. HENRY B. GONZALEZ, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GONZALEZ. Mr. Chairman, I am pleased to have this opportunity to address my remarks to you and the committee members on the 6-month waiting period a person disabled and unemployed must endure after his application for social security disability benefits has been approved.

I would call the situation painfully inequitable. While a waiting period is a hardship for anyone in need, clearly, the hardship is greatly multiplied for one who is physically incapable of caring for himself. The 6-month period, I strongly believe, should be completely eliminated.

Thousands of people are enduring hardships because they believe that in the event of sudden disability they will be able to rely on their only source of assistance—their social security benefits; but, the rude truth is that or 6 months they will not be able to work, nor will they have a source from which to pay their rent, their debts, their medicines, or even money with which to buy food stamps or the special diet food which they must have in order to control their particular disease.

I believe you will find that both the local social security offices and congressional offices encounter persons almost daily who very definitely meet the requirements of having a disabling condition and who unquestionably suffer hardships as a direct result of the 6-month waiting period. Once their application has been approved, a letter is sent to the individual—the young man with a young family, the widow, the old retiree—telling him yes, your disability is severe enough to

prevent you from engaging in substantial work and yes, your illness is expected to last more than a year or may even result in death, but there is a law in the books that says we have to wait 6 months to see if you are really ill. What more proof is needed to point to when the obvious fact is that the man is physically incapacitated as the result of a stroke, or has been diagnosed as having a terminal case of cancer or an uncontrollable case of diabetes. These cases necessitate us to look again at that law in light of the specific instances of hardships incurred.

If the social security disability benefits law is to be strict in determining a disability condition and the necessity of a long duration of the illness, then I should think whoever qualifies ought to be allowed to receive benefits due them at the onset of their illness.

One of the points made in opposition to removing the waiting period is that some cases, as those which are not terminal, cannot be definitely defined as lasting more than a year. However, I think the physicians' discretion in determining the severity of disabilities could also be extended to suggest that according to previous cases of this type in their numerous medical experiences, the illness is "likely" to last for more than 1 year. And even if the impairment would not last the year, but only 8 or 9 months, this would not necessarily be a disaster. The benefits would be immediately cut off, the aid could not be considered a waste, and thousands of others which remained disabled would not be penalized during those first 6 months.

Equity, gentlemen, is singularly the crux of my rhetoric—and I hope that you will see the necessity of passing out legislation which will remove this limitation. And I urge you not to merely reduce the waiting period but to eliminate it completely; because after a traumatic recognition that one is no longer able to earn a living because of a disabling condition, 1 month or 6 months will be an added burden.

Your favorable consideration of this proposal would be greatly appreciated. Thank you.

Mr. BURKE. Thank you, sir. Would any one like to question Mr. Gonzalez? If not, thank you for coming to the committee.

Our next witness this morning is Dr. Russell B. Roth, and Mr. Bernard P. Harrison, of the American Medical Association.

Is Dr. Roth here?

We welcome you to the committee, Dr. Roth, and you may proceed.

**STATEMENT OF DR. RUSSELL B. ROTH, ON BEHALF OF THE
AMERICAN MEDICAL ASSOCIATION; ACCOMPANIED BY BER-
NARD P. HARRISON, DIRECTOR, DEPARTMENT OF LEGISLATION**

Dr. ROTH. Mr. Chairman, and members of the committee, I am pleased to be here today to present the comments of the American Medical Association with respect to proposals to amend the various titles of the Social Security Act. As the committee knows, our interest lies in many of the topics before you. However, I plan to speak about only one of the subjects which concerns the committee during the course of these hearings—to ask for the careful consideration of the AMA's proposal to provide a health care program for the Nation.

It has become clear to all of us that even this country, with all its wealth, has financial limits as to what it can undertake. Representing this country's physicians as we do, the AMA is on record in its belief that it is the basic right of every citizen to have available to him good health care.

We believe that, without good health, it is impossible for any citizen to lead a full, productive and meaningful life.

Today we want to put before this committee a plan which is universal in scope, voluntary in nature, and realistic in terms of total program cost.

This proposed program is one that the AMA calls medicredit. It is a flexible program which would assure every individual and family—no matter how limited their financial resources—of adequate health protection.

For those in low-income categories, this protection is theirs without expense or contribution on this part. For those with moderate and higher levels of income, medicredit provides a system of cash incentives to enable them to protect themselves against major health care costs.

Medicredit would not replace medicare—which, as you know, provides health care protection for those 65 and over. Medicare would remain as it is.

Medicredit would, however, do away with the need for medicaid.

Our proposal is the result of years of careful study of our existing mechanisms for delivering and financing health care, coupled with our close study of the Federal Government's ability to fund a universal health insurance program.

Now, let me explain how medicredit would work. It would give to persons who have purchased comprehensive health insurance the option of receiving a tax credit on their annual Federal income tax return, a credit based on their tax liability. That is, a taxpayer could take as a credit against the amount of income owed to the Federal Government, all or part of his personal cost for comprehensive health coverage. Persons or families with a lower tax liability (usually reflecting lower income or more dependents with allowable expenses) would receive a greater tax credit. And those families in the lower 30-percent income range, would, without cost to them, receive a certificate enabling them to purchase health coverage from qualified groups or plans.

Mr. Chairman, that is but the barest outline of the AMA proposal. Permit me in the time allotted to describe our proposal in just a little more detail so that your committee may have sufficient information before it.

The more formal statement, sir, would be that I am Russell B. Roth, a physician in private practice, specializing in urology, in Erie, Pa. I am speaker of the American Medical Association's house of delegates. Prior to election to that office, I was chairman and a member of the AMA Council on Medical Service. It was while serving in that capacity that I developed a special interest in the health care needs of all our citizens and in the available mechanisms for providing quality health care to all persons. Incidentally, that interest also led to my participation, along with other physicians of the AMA, in committees and task forces formed by the Secretary of Health, Education, and Welfare immediately after the adoption of the medicare law for the purpose of speedily and effectively implementing the medicare pro-

gram. These committees worked diligently to get the program off the ground and into operation, and much of the early success of medicare has to be attributed to their efforts.

Seated with me is Mr. Bernard P. Harrison, an attorney and director of our legislative department, who has appeared before this committee on other occasions with other witnesses for this association.

It is important to recognize that our plan envisions improvements, extensions, and refinements of what we have already evolved in this country, rather than the devising of radical replacements.

The shortcomings of our system, whatever they may be, stem from the rapid, relatively uncontrolled growth of medical technology, the staggering increase in demand, and American compulsion to experiment, innovate, and improvise in an atmosphere of freedom of enterprise and the competition of the marketplace. To a great degree our difficulties stem from the successes of our health care system rather than from its failures.

The financial mechanisms which have been developed in this country to meet the costs of medical care have been successful and progressive. We believe that, in our future, there continues to be a proper place for private insurance, for voluntary prepayment plans, for protection against health care costs through prepaid comprehensive group practice, and for other innovative approaches. They all help to mobilize the available resources of the private sector of our economy to meet the need of our Nation for health care services.

In consequence of these considerations, the American Medical Association has sought to devise a financial mechanism which, insofar as possible, would meet the needs of the public on a voluntary basis, with maximum incentives for participation. Ours is not a plan developed in the last few weeks as a response to the chairman's call for these hearings. We have been with this concept for years and have spent months in the development of a program to be offered to the Congress, one which would realistically meet the needs of our people.

Our plan recognizes that the population may be divided into three fairly well-defined categories with respect to ability to purchase comprehensive health insurance.

There are those with essentially no capacity to pay;

There are those with a capacity to pay a portion of the cost; and

There are those with a reasonably full capacity to pay.

For those who have no capacity to pay for health insurance. The Government would pay for basic comprehensive health coverage by providing to the individual or head of the family a certificate which may be used for the purchase of a two-part package of insurance—part I, hospital care, and part II, physicians' services, wherever rendered. For those with a low-tax liability (say \$300 or less) a similar certificate good for the purchase of comprehensive health insurance would be provided. For those with tax liability above that amount, and please note we are speaking of tax liability and not taxable income, income tax credits would be given on showing of expenditures for qualified health care plans. The amount of the credit would be based on the tax liability of the person or family so that, for example, a taxpayer with a \$500 tax liability might receive 70 percent of the annual premium cost as a credit against his tax liability, and a family with \$1,200 tax liability might receive 20 percent of the premium expense as a credit against their tax liability.

In order to receive the credit the taxpayer would need to show that he has purchased a qualified insurance or prepayment plan. Such a qualified plan would be one where both the benefit package and the carrier or group has been approved by the appropriate State agency. Guidelines would be established to assist the State agency in this qualifying program.

To provide the guidelines necessary to carry out the purposes of the bill, and to plan and develop programs for maintaining the quality of medical care and the financial resources and effective utilization of available health manpower and facilities we propose the establishment of a Health Insurance Advisory Board. This board which would be chaired by the Secretary of Health, Education, and Welfare and include the Commissioner of Internal Revenue and public members, would review the effectiveness of the program and file annual reports with the President and the Congress.

Mr. Chairman, a draft of the American Medical Association's bill is available to the committee for its review and consideration.

You will find that the AMA bill requires as basic benefits under any qualified plan, 60 days of inpatient hospital services, including maternity services; all emergency room and out-patient service provided in the hospital; and all medical services provided by a doctor of medicine or a doctor of osteopathy whether performed in the hospital, home, office or elsewhere. Supplemental benefits may also be provided and payment for such benefits would be eligible for tax credit, or in the case of the lower income persons for the certificate which entitles them to purchase the qualified plan of their choice.

Mr. Chairman, most advocates of change in our health care system support the use of the insurance mechanism as an essential part of any program. Without Blue Shield, Blue Cross, and commercial carriers under contract with the Social Security Administration, the medicare program would have been an administrative shambles.

We urged then, and still do now, even further involvement of this private sector in the medicare program. Similarly, we believe that any new program which hopes for success in the delivery of quality health care at reasonable costs, must call upon the insurance industry and prepayment plans to play a significant independent and competitive role.

According to figures of the Health Insurance Association of America, 89 percent of our civilian, noninstitutional population under age 65, have some form of health insurance protection. The concept of protecting against health care expenses is one which is approved and accepted by almost all of our people. The difficulty which we experience today lies in the rising costs of health care and the corresponding rising costs of plans designed to protect against such expenses.

There are numerous organizations and individuals who are seeking today the answers to the many faceted problems of health manpower, shortage of care in certain urban pockets, and the rising cost of health care. We believe that the approach we offer, in the immediate and long-range view, is the right way to meet the problem of financing health care costs. It does away with the need for a medicaid program for the low-income group and offers in its place a system which brings the private competition factor into the picture, and places all citizens truly in the mainstream of health care. For the higher income individuals and families, it offers realistic incentives to purchase com-

prehensive health care coverage. It utilizes to the fullest extent the private carriers and plans and allows for the marketplace to play an active part in maintaining cost control and insuring quality programs, as it has done for so many years in this country's history. Mediredit would be relatively easy to manage and the administrative cost to the Government would be less than that of other proposals now being advanced.

We believe that mediredit merits your careful consideration and we stand ready to do our best to provide whatever information the committee may require.

Mr. Chairman, in addition to copies of the draft of the AMA bill, we have also submitted our critique of the Health Cost Effectiveness Amendments of 1969, as presented by HEW. We view this proposal as one which could critically affect the medicare and other federally-supported health programs, and we ask that you give our comments your most careful attention.

Now, Mr. Chairman, Mr. Harrison and I will attempt to answer any questions the committee may have.

(The documents referred to follows:)

SUPPLEMENTAL STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION*

The American Medical Association shares the concern for rising health care costs with the Administration, the Congress, the public, and providers of services. Rising costs affect not only the individual patient, but also federally supported and financed programs, particularly medicare, medicaid and programs under Title V.

A proposal submitted by the Department of HEW, and known as the "Health Cost Effectiveness Amendments of 1969," is intended to curtail the rising costs of health care, and in this regard the Administration is to be commended. We believe, however, that there are better and more appropriate means of meeting this problem.

Following is a brief description of provisions of the proposal, and we urge the Committee on Ways and Means to carefully consider our comments and recommendations.

(1) *Section 2* provides that in order for a provider of service to receive allowance for depreciation for a capital expenditure, or for interest on funds borrowed for such expenditure, it would have to either give 60 days notice to or receive the approval of the state comprehensive health planning agency.

Many improvements made by providers of service meet the approval of the state Hill-Burton agency or the local areawide planning agency. The requirement for approval by the state comprehensive planning agency would subordinate the important roles played by the other agencies. We recommend that the allowance should not be denied where the approval of any of the recognized agencies has been received.

(2) *Section 3* would require a provider of services to have in effect an overall plan and budget filed with the comprehensive health planning agency.

We believe the requirement that there should be medical staff representation on the institution's planning committee is a good one.

(3) *Section 4* expands the present provisions with respect to incentive reimbursement experiments to provide that the Secretary could develop and engage in experiments and demonstration projects directly or by grants with public or non-profit private agencies, institutions or organizations. The purpose of such projects are stated in the section. While voluntary participation of institutions and organizations would be sought, the Secretary can require participation. (Under the present law participation is on a voluntary basis, and the parties agree to a basis of reimbursement.) Exception will be made if one or more organizations and institutions, equal to at least 20% of those required to participate, establish that participation would cause them undue hardship (undefined in the bill). Failure

*Submitted with testimony of the American Medical Association before this Committee on November 3, 1969, by Russell B. Roth, M.D.

to participate, where required, or participation under circumstances which the Secretary determines not to be good faith participation, would make the institution or organization ineligible for medicare payments, and the federal share of medicaid and Title V payments would be withheld for their services, for such period as the Secretary finds appropriate.

It should be noted that an institution or organization, even after a finding of undue hardship, could be compelled to participate.

We believe that the provision for involuntary participation under the terms of the bill are harsh. Institutions and organizations should be defined and this section revised to remove any potential constraint on a physician to participate in any project against his will, directly or through any organization to which he belongs. The term "undue hardship" should be defined in the law, and any institution or organization which does establish such hardship should not be required to participate.

It further appears that participants in the experiments program are eligible without meeting present standards of eligibility applicable to medicare participants. This raises a question as to the quality of care which might be provided.

We also believe that local institutions and organizations should be involved in the development of projects and appropriate associations should be consulted before plans are finalized.

(4) *Section 5* prohibits payments under Part B for medical or health services, or, as to nonparticipating hospitals, for emergency outpatient services, if the Secretary finds that the person furnishing services: has made false statements of material facts; has failed to provide information Secretary finds necessary; has refused to permit examination of his fiscal and other records by the Secretary; has submitted bills containing charges substantially in excess of his customary charges (without good cause for such excess charges); or has furnished services or supplies determined by the Secretary, with concurrence of a medical review team, to be substantially in excess of needs of or to be harmful to individuals or to be grossly inferior in quality.

Any determination made by the Secretary is effective, after public notice of his finding, as to all future services of the individual (until reinstated to participate in the program). Administrative hearings and judicial review are provided, but after the public notice has been given.

Similar provisions are included to enable the Secretary to terminate agreements with providers of services.

This ban could apply to other programs. Where any person or provider is cut off from participation under medicare, the state cannot be paid under medicaid or Title V programs for services furnished by such individuals or institution.

It also provides that the Secretary after consultation with HIBAC, and national medical societies, shall create a national program of medical review and evaluation of: (a) the quality of services and supplies furnished to individuals; (b) the extent of which such services and supplies are being furnished for purposes other than meeting the health needs of such individuals; and (c) such other factors relating to furnishing of services and supplies as may impinge upon the physical and mental well-being of such individuals.

The Secretary, after consultation with appropriate state and local professional societies and the appropriate medicare carriers, would appoint one or more medical review teams (composed of physicians and other professional personnel in the health care field) in each state. Among other things, they would review particular cases where there is a likelihood that the person or persons furnishing services and supplies to individuals may come within the provisions relating to overcharging and improper and inferior services.

It should be kept in mind that there presently exist remedies to reach the cases of abuse which may exist—certainly the cases of extreme abuses which HEW has asserted these proposed penalties are intended to reach. While it is true that the law does not provide authority to disqualify physicians as to prospective participation, a carrier may reject or review a physician's claims on an individual basis as each claim is presented.

The apparent concern of the Congress regarding alleged abuses and increasing program costs may require some changes in the administration of federally financed health care programs. However, the proposed amendments appear to introduce more severe remedies than the problems require.

We strongly recommend (1) deletion of the right of the Secretary to make the broad inspections proposed; (2) delete paragraph (C), since the medicare program ought not to concern itself with a physician-patient relationship outside the program; (3) delete paragraph (D), as the terms "substantially in

excess of the needs of individuals," "harmful," services and those "grossly inferior," stated as the bases for disqualification, involve subjective medical judgments which defy accurate medical judgment; (4) limit the medical review committee to the function of reviewing disputed claims, and not evaluating the national program. The bill should be amended further to provide that the Medical Review Team, and its functions, shall be the responsibility of the state medical society unless it fails to act. In the latter case the Secretary should be empowered to appoint. As a less desirable alternate, the members of the Medical Review Team could be appointed from a list submitted by the medical society.

Further it should provide for public notice of disqualification only *after* the hearing and the court review; and provide penalties for abuse in the program and sequential warning, temporary suspension (30, 60 days, etc., depending on degree of offense and whether second offense, etc., up to a period of three months).

(5) *Section 6* permits payment to providers of service at less than the reasonable cost when such providers customarily charge less than cost for other patients. If a "public provider" furnishes services free or for a nominal payment, HEW can determine fair compensation.

While *Section 6* appears to be a reasonable one, it should be kept in mind that some hospital charges will undoubtedly increase as a result.

(6) *Section 7* would require a utilization review committee of an institution to determine whether: (1) admission to the institution, or (2) further stay, or (3) furnishing of particular professional services (including drugs and biologicals) was medically necessary, and promptly to notify the institution, patient and physician where the finding is negative. The law would then prohibit payments where any such finding has been made.

At the present time a Utilization Review Plan of an institution must provide for review, on a sample basis or other basis, of admissions, duration of stays, and services furnished but must provide for review of each case of extended stay and also determine medical necessity of further stay. The law provides for 3 additional days of benefit payments after a negative finding and notification.

Where a finding has been made that the admission was unnecessary, no payment would be made. Thus the denial of payment would be retroactive to the date of admissions. The 3-day grace period is removed from existing law.

The AMA previously objected to initial certification of the need for admission to a hospital, and this initial certification requirement was removed from the law. Under this bill the utilization review committee would be required to review the attending physician's judgment as to the need for hospitalization. The present requirement of the UR committee under medicare is to review extended stay cases to determine need for further stay; thus it does not review a great number of cases of hospitalization where the patient is discharged earlier. Requiring committees to review all cases of hospitalization would impose a tremendous burden on the committee, and create additional heavy demands on physicians' productive manhours.

An adverse finding by a committee would subject the patient to individual liability for hospital charges. As a result, this provision could act as a restraint on patients receiving care, particularly in those cases where a physician recognizes the possibility of differing medical judgments concerning the admission.

We believe that this section of the bill should be deleted entirely.

In the event that this cannot be accomplished, then the provision in present law permitting 3-days' benefit payment following the date of such determination should be retained and made applicable to admissions and long-term stay by adding at the end of proposed section 7(b) the following: "except that, if such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or extended care facility, as the case may be, received notice of such finding."

(7) This section would permit the Secretary, when he finds that more than the correct amount has been paid to a provider of services or other person for services under medicare, to correct such overpayment by requiring refunds or by reducing subsequent payments. When necessary, he could determine the "excess amount" on the basis of estimates, sampling, or other methods which approximate the excess.

We believe that *Section 8* should be clearly limited to those providers who are paid on a reasonable cost basis, where such approximations could apply.

If this is not done, then the section should be amended to provide that, where payment has been on a reasonable charge basis, the excess payment shall be the amount of actual payment less the reasonable charge for the specific service rendered.

Before closing, one further comment is required inasmuch as the HEW proposal omits an opportunity to effectively cut costs in government programs and to upgrade the quality of care provided. At the present time, the medicaid program allows the states to furnish chiropractic services to individuals. Pressure continues for the inclusion of such services under medicare. The following statement, contained in the unbiased and independent study made by the Department of HEW, at the request of the Congress, describes chiropractic:

Chiropractic theory and practice are not based upon the body of basic knowledge related to health, disease, and health care that has been widely accepted by the scientific community. Moreover, irrespective of its theory, the scope and quality of chiropractic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment. Therefore it is recommended that chiropractic service not be covered in the medicare program.

The National Council on Senior Citizens has publicly stated:

Chiropractic treatment, designed to eliminate causes that do not exist while denying the existence of the real causes, is at best worthless—and at worst mortally dangerous.

In the interest of effectively cutting costs and providing quality care, the medicaid program, should be amended to exclude payment for such services and the Congress should resist any recommendations for its inclusion under medicare.

In closing, general comment is germane at this time. When the medicare law was adopted by the Congress, section 1801 provided assurance of freedom from interference with the practice of medicine. The profession and the public accepted this assurance in good faith. The integrity of this commitment compels the most careful scrutiny of the proposed legislation.

SUMMARY OF PROVISIONS CONTAINED IN A BILL "TO PROVIDE FOR MEDICAL AND HOSPITAL CARE THROUGH VOLUNTARY HEALTH INSURANCE FINANCED IN WHOLE OR IN PART BY INCOME TAX CREDITS"

Section 1 declares that it is in the public interest for the government to provide assistance and encouragement to all persons who seek protection for insuring against the expenses of illness and that private health insurance coverage is an appropriate means to do so since, through competition, incentives are provided for the lowering of health care costs, the introduction of innovations in the delivery of health care and the maintaining of quality health care. It then states, as the bill's purpose, to provide a mechanism for every resident to obtain comprehensive health insurance of his choice.

Section 2 amends the Internal Revenue Code by adding a new section of income tax credits for the cost of health insurance premiums. Subsection (a) sets out how the amount of credit is calculated and names as eligible taxpayers every individual who elects to be covered under this Act and who is not eligible to receive military medical care. The tax credit is a percentage of the actual cost of the insurance premium(s), with the percentage based on the individual's tax liability as computed on his personal income tax return. The percentage ranges from a high of 100% for the individual with a tax liability of \$300 or less to a low of 10% for the individual with a tax liability of more than \$1300. Subsection (a) further states that the credit is available only if the premium(s) have been paid for "qualified medical care insurance policies" covering the taxpayer, his spouse, and dependents.

In the event that more than one policy is purchased by the taxpayer, subsection (b) limits the total credit to the applicable percentage determined by the table provided in subsection (a).

Subsection (c) provides that the taxpayer may elect to receive a "health insurance certificate" equal to the applicable percentage of the allowable premium. The certificate is to be redeemed by the carrier who accepts it in payment of the premium for a "qualified medical care insurance policy." In order to be so qualified, the carrier and the plan must be registered by the appropriate state agency.

Subsection (d) defines a "qualified medical care insurance policy" as one offered by a carrier who has been registered in the state by the appropriate agency, which has also registered the package of benefits and premium offered by the carrier. The "qualified" policy must include:

Part I.—60 days of inpatient hospital services and emergency room and outpatient services; and

Part II.—All medical services wherever rendered.

Deductibles and coinsurance:

Part I.—\$50 on inpatient services, 20% of the first \$500 incurred expenses for emergency room and outpatient services;

Part II.—20% of the first \$500 incurred expenses.

The qualified policy may also include any of the following as supplemental coverage:

Part III.—Prescription drugs (\$50 deductible per year); additional hospital days (20% coinsurance); cost of blood in excess of three pints; and other personal health services furnished pursuant to written direction of a physician (20% coinsurance).

A carrier is defined as a voluntary association, corporation, partnership, etc., or other non-governmental organizations, lawfully offering a health benefits insurance plan.

Subsection (e) provides for the redemption by the IRS of health insurance certificates.

Subsection (f) provides technical amendments and subsection (g) establishes an eleven man Health Insurance Advisory Board to include the Secretary of HEW, the Commissioner of IRS, and nine public members. The duties of the Board are set out in subsection (h) and include the development of guidelines and regulations to establish minimum standards for the care of state insurance departments in qualifying a carrier and its plan, and the development of programs for the maintaining of quality medical care and the effective utilization of available financial resources, health manpower and facilities, through means which provide for the participation of carriers and providers of service.

Subsections (i) and (j) provide authority for the state designated agency to qualify carriers and plans and issue registration numbers to those so qualified, and subsection (k) requires an employer or an association which purchases a qualified policy to notify its employees of the amount of their contribution and the registration number of the policy.

Section 3 provides that the Part B medicare enrollee may use his health insurance certificate to pay for his Part B premium expense.

Section 4 authorizes the Secretary of HEW to contract with a state to insure coverage under this program for Title XIX (medicaid) eligibles in that state.

Section 5 is a prohibition against federal interference—similar to the prohibition contained in the medicare law.

Section 6 provides that the effective date of the Act shall be the taxable year beginning after December 31, 1969.

[Bill No. —, 91st Cong., first sess.]

A BILL To provide for medical and hospital care through a system of voluntary health insurance financed in whole or in part by income tax credits

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Health Insurance Assistance Act of 1969."

FINDINGS AND DECLARATION OF PURPOSE

SECTION 1. (a) The Congress finds: (1) that the resources of many individuals are inadequate to meet the expenses of major illness; (2) that private health insurance coverage is an appropriate mechanism for insuring against such expenses in that through competition incentives are provided for the lowering of health care costs, the introduction of innovations in the delivery of health care, and the maintaining of quality health care; (3) that such coverage for all persons is a desirable national objective; (4) that health insurance should be made available to all citizens regardless of previous medical history; and (5) that it is in the public interest to provide government assistance and encouragement to individuals who seek the protection of insuring against the expenses of illness.

(b) The purpose of this Act is to make it possible for every individual to obtain comprehensive medical and hospitalization insurance of his choice, subject to minimum standards, designed to protect against the costs of customary illness as well as major medical expenses, on a guaranteed renewable basis and regardless of prior medical history.

INCOME TAX CREDIT FOR MEDICAL CARE INSURANCE PREMIUMS

SEC. 2. Part IV of subchapter A of chapter I of the Internal Revenue Code of 1954 (relating to credits against tax) is amended by redesignating section 40 as section 41, and by inserting after section 39 the following section:

"SEC. 40. COST OF MEDICAL CARE INSURANCE PREMIUMS

"(a) Allowance of Credit to Individuals—

"(1) Determination of Amount of Credit—Every individual determined to be eligible under subparagraph B of paragraph 3 and who is not eligible to receive military medical care shall be allowed, at his election, a credit against the tax imposed by this chapter for the taxable year in an amount equal to the applicable percentage of the allowable premium (determined under paragraph (3)) paid during the taxable year by such individual.

"(2) Applicable Percentage—The applicable percentage for each taxpayer will be based on tax liability and determined under the following table:

Income tax liability and percentage of allowable premium credited against income tax

Income tax liability:	Percent	Income tax liability—Continued	Percent
Under \$300-----	100	\$801 to \$825-----	28
\$301 to \$325-----	98	\$826 to \$850-----	26
\$326 to \$350-----	95	\$851 to \$875-----	24
\$351 to \$375-----	91	\$876 to \$900-----	22
\$376 to \$400-----	87	\$901 to \$925-----	20
\$401 to \$425-----	84	\$926 to \$950-----	20
\$426 to \$450-----	81	\$951 to \$975-----	20
\$451 to \$475-----	77	\$976 to \$1,000-----	20
\$476 to \$500-----	73	\$1,001 to \$1,025-----	20
\$501 to \$525-----	70	\$1,026 to \$1,050-----	20
\$526 to \$550-----	67	\$1,051 to \$1,075-----	20
\$551 to \$575-----	63	\$1,076 to \$1,100-----	20
\$576 to \$600-----	59	\$1,101 to \$1,125-----	20
\$601 to \$625-----	56	\$1,126 to \$1,150-----	20
\$626 to \$650-----	53	\$1,151 to \$1,175-----	20
\$651 to \$675-----	49	\$1,176 to \$1,200-----	20
\$676 to \$700-----	45	\$1,201 to \$1,225-----	18
\$701 to \$725-----	42	\$1,226 to \$1,250-----	16
\$726 to \$750-----	39	\$1,251 to \$1,275-----	14
\$751 to \$775-----	35	\$1,276 to \$1,300-----	12
\$776 to \$800-----	31	Over \$1,300-----	10

"(3) Allowable Premium—

"(A) Except as provided in subparagraph (D), the allowable premium is the aggregate amount of premiums paid in behalf of eligible beneficiaries (defined in subsection (B)), during the taxable year under one or more qualified medical care insurance policies (defined in subsection (d) (1) by the taxpayer, or by his employer in his behalf and from the taxpayer's funds.

"(B) 'Eligible beneficiary' shall include the taxpayer, his spouse, and dependents as defined in Sec. 152. For purposes of this provision, a child of divorced or separated parents, shall be an eligible beneficiary of the parent who has custody and who has paid the allowable premium.

"(C) Tax credit shall be allowed for aggregate amounts of premiums on more than one qualified medical care insurance policy only to the extent that such combination of policies does not provide duplicate coverage of health care costs for any eligible beneficiary.

"(D) Special Rule in the Case of Ineligible Beneficiaries—If the taxpayer pays premiums for a qualified medical care insurance policy which includes coverage for an ineligible beneficiary, then for purposes of subparagraph (A) in determining the aggregate amount of premiums paid there shall be included only that portion of the premium for such policy which bears the same ratio to the amount of the premium paid by the taxpayer as the number of eligible beneficiaries of such policy bears to the total number of beneficiaries of such policy.

"(4) Disallowance of Medical Expense Deduction—If an individual elects to take the credit under paragraph (1) for the taxable year, no amount paid in such taxable year by such individual for a qualified medical care insurance policy shall be allowed as a deduction under any of the provisions of section 213 (relating to deductions for medical expenses).

"(b) Limitations on Amount of Credit—The maximum credit allowed to a taxpayer by subsection (a) of this section for a taxable year shall equal the appropriate applicable percentage of the sum expended for a qualified program for eligible beneficiaries.

"(c) Election—

"(1) Manner of Election—The election of a taxpayer to take the credit under subsection (a) for a taxable year shall be made at such time and in such manner as the Secretary or his delegate shall prescribe by regulation.

"(2) Health Insurance Certificate—A taxpayer may elect to receive in lieu of a tax credit, a health insurance certificate equal in amount to the applicable percentage of the allowable premium; providing, however, that for the purposes of this paragraph, the premium need not have been paid in advance of the issuance of the health insurance certificate.

"(3) Registration Number Required—An individual who elects to take the credit under subsection (a) for a taxable year with respect to premiums paid for a qualified medical care insurance policy shall, under regulations prescribed by the Secretary or his delegate, affix to his income tax return the registration number of the carrier which has provided the qualified medical care insurance policy.

"(d) Definitions and Special Rules—For purposes of this section—

"(1) Qualified Medical Care Insurance Policy—The term 'qualified medical care insurance policy' means: (a) a contractual or other right to benefits under a program offered by a carrier, which carrier and program have been registered by the state insurance department or by such other agency as may be authorized by the state, and which provides base coverage and which requires the payment of premiums; or (b) the Supplementary Medical Insurance Benefits for the Aged program Part B, Title 18 of the Social Security Act as amended). A qualified medical care insurance policy may include supplemental coverage in addition to base coverage.

"(2) Base Coverage—(A) The term 'base coverage' means a program offered by a carrier which provides protection against the basic costs of medical care without regard to any pre-existing health condition, and is guaranteed renewable so long as the carrier continues to offer to the public one or more qualified medical care insurance policies.

"(B) Base Coverage shall include:

"(1) Hospital (Part I):

"(a) Inpatient hospital services, including maternity services, for up to sixty days during any policy period, in semi-private accommodations; inpatient hospital services shall include all services customarily charged for by the hospital, except for convenience items such as telephone and television. Benefits under this paragraph shall be subject to a payment of \$50 by the beneficiary for costs incurred during each hospital stay.

"(b) Emergency room or outpatient services when performed in the hospital for the beneficiary on an outpatient basis, and billed for by the hospital; such services shall be subject to a 20% coinsurance payment by the beneficiary of the first \$500 of expenses incurred during a policy period.

"(2) Medical (Part II):

"All medical services, including diagnostic and therapeutic, provided by a doctor of medicine or doctor of osteopathy who is duly licensed to practice medicine or osteopathy, when such services are provided in the hospital, home, office, or elsewhere; services provided under this paragraph shall be subject to a 20% coinsurance payment by the beneficiary of the first \$500 of expenses incurred during a policy period.

"(C) Coverage provided under Parts A and B of Title 18 of the Social Security Act as amended shall, for purposes of this Act, meet the requirements for base coverage.

"(3) Supplemental Coverage (Part III)—(A) The term 'supplemental coverage' means a program of benefits, in addition to those provided as base coverage, offered under a qualified medical insurance policy. Any carrier providing a plan for supplemental coverage must make such plan available to all subscribers to its qualified medical insurance policy.

"(b) Supplemental coverage may include as benefits provided during the policy period, one or more of the following:

"(1) Prescription drugs not otherwise covered, subject to a \$50 deductible during each policy period;

"(2) Additional days of inpatient hospital services, subject to a 20% coinsurance payment by the beneficiary;

"(3) The cost of blood furnished in excess of three pints;

"(4) One or more other personal health services, including diagnostic and therapeutic, but only when rendered by a provider licensed (or registered) to provide such services by the appropriate state agency and when furnished pursuant to the written direction of a physician; such services shall be subject to a 20% coinsurance payment by the beneficiary.

"(4) Health Insurance Certificate—means a certificate issued by the Secretary or his delegate to an eligible beneficiary for the payment of a qualified insurance policy, and which may be redeemed only as provided in subsection (e).

"(5) Carrier—The term 'carrier' means a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization.

"(6) Liability for Tax—The term 'liability for tax' means the amount of the tax imposed by this chapter for the taxable year, reduced by the sum of the credits allowable under sections 33 (relating to foreign tax credit), 34 (relating to credit for dividends received by individuals), 35 (relating to partially tax-exempt interest), 37 (relating to retirement income), and 38 (relating to investment tax credit), but not reduced by the credit allowed under this Act.

"(7) Marital Status—Section 153 shall apply in making any determination of marital status.

"(8) Secretary—Means the Secretary of the Treasury unless otherwise specified.

"(9) Policy Period—The term 'policy period' means the 12 consecutive month period beginning with the effective date of the policy or contract.

"(10) Physician—The term 'physician' means an individual who is a doctor of medicine or doctor of osteopathy and who is licensed to practice in the state where the medical services are provided.

"(e) Redemption of Health Insurance Certificate—The Secretary shall issue regulations which shall provide for the redemption of health insurance certificates which have been certified to have been accepted by an insurance carrier in full or part payment for a qualified medical care insurance policy.

"(f) (1) The table of sections for such part IV is amended by striking out

'Sec. 40. Overpayments of tax.' and inserting in lieu thereof

'Sec. 40. Costs of medical care insurance premiums.

'Sec. 41. Overpayments of tax.'

"(2) Section 213(e) (1) (C) of such Code (relating to medical expense deductions) is amended by inserting 'subject to section 40(a) (4)' after '(C)'.

HEALTH INSURANCE ADVISORY BOARD

"(g) There is hereby created a Health Insurance Advisory Board (herein after referred to as the Board) which shall consist of eleven persons including the Secretary of Health, Education, and Welfare and the Commissioner of the Internal Revenue Service, or their delegates. The remaining members, not otherwise in the employ of the Government, shall be appointed by the President, with the advice and consent of the Senate, without regard to the provisions of title 5, United States Code, governing appointment in the competitive service. The Secretary of Health, Education, and Welfare shall serve as Chairman. The members shall be selected from persons who are specifically qualified to serve on such Board by virtue of their education, training, or experience.

"Each of the public members shall be appointed for a term of four years except that when first appointed, three shall be appointed for terms of two years, three for terms of three years, and three for terms of four years, and except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term. The Secretary of Health, Education, and Welfare may appoint such special advisory professional or technical personnel or committees as may be needed to carry out the purposes of this Act. Members of the Board and other personnel or members of any advisory or technical committee, while attending meetings or conferences thereof or otherwise serving on business of the Board or of a committee, shall be entitled to receive compensation at rates fixed by the Secretary of Health, Education, and Welfare, but not exceeding \$100 per day, including travel time, and while so serving away from their business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently. The Board shall meet as frequently as the Chairman deems necessary. Upon request of four or more members, it shall be the duty of the Chairman to call a meeting of the Board.

DUTIES OF HEALTH INSURANCE ADVISORY BOARD

"(h) (1) The Health Insurance Advisory Board shall: (a) prescribe such regulations as may be necessary to carry out the purposes and provisions of this Act, (b) establish minimum federal standards for the use of state insurance departments in determining whether an insurance company and plan are qualified under this Act, (c) plan and develop programs whose purposes are to provide for maintaining the quality of medical care, and the effective utilization of available financial resources, health manpower and facilities, through utilization review, peer review and other means which provide for the participation of the insurance carriers and the providers of services, (d) review the effectiveness of the tax credit program and file, by July 30 each year, with the President and the Congress an annual report: (1) on the operation and status of the program during the past fiscal year and on its expected operation during the current and next two fiscal years; and (2) with recommendations for such changes in the law designed to improve the effectiveness of the program.

"(2) The Board is authorized to request from any department, agency, or independent instrumentality of the Government any information it determines is necessary to carry out its functions under this Act, and each such department, agency, or independent instrumentality is authorized to cooperate with the Board, and to the extent permitted by law, to furnish such information to the Board upon request made by the Chairman.

"(i) The state insurance department or other agency designated by the state shall determine the qualifications of each carrier which plans to offer a qualified medical care insurance policy to residents of that state, and when a carrier is determined to be qualified to offer such a policy, shall issue to said carrier a registration number.

"(j) The state insurance department, or other agency designated by the state, within the standards set by the Health Insurance Advisory Board, shall approve the insurance plan for base coverage and premium rate to be charged therefor, and assign to such plan a qualified medical care insurance policy registration number.

"(k) An employer or association purchasing a qualified policy shall notify employees or members of the amount of their health insurance contributions and the registration number of the policy."

SEC. 3. Section 1840 of the Social Security Act (relating to payment of premiums for supplementary health insurance for the aged) is amended by adding at the end thereof the following new section:

(j) (1) Under regulations of the Secretary, an individual may apply towards the payment of his premiums for insurance under this part, a health insurance certificate issued to him under section 40 of the Internal Revenue Code of 1954. When so applied, subsections (a), (b), (c), (d), and (e) of this section shall not apply to the monthly premium of such individual for any applicable month.

(2) There is authorized to be appropriated, from time to time out of any monies in the Treasury not otherwise appropriated to the Federal Supplementary Medical Insurance Trust Fund, an amount equal to the aggregate amount of premiums paid with health insurance certificates under paragraph 1. For purposes of section 1844(a) (1), sums authorized to be appropriated pursuant to this paragraph shall be considered premiums payable under this part and deposited in such trust fund. Such certificates upon presentation to the Secretary of Health, Education, and Welfare or his delegate, shall be redeemed through payments from the Federal Supplementary Medical Insurance Trust Fund.

SEC. 4. The Secretary of Health, Education, and Welfare shall, at the request of a state, enter into an agreement with such state pursuant to which all beneficiaries eligible under this Act and who are eligible for participation under the Social Security Act Title XIX program in effect in that state, may subscribe to a qualified medical insurance policy.

PROHIBITION AGAINST ANY FEDERAL INTERFERENCE

SEC. 5. Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure or compensation of any officer or employee or any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person."

SEC. 6. This Act shall apply with respect to taxable years beginning after December 31, 1969.

Mr. BURKE. Are there any questions?

Mr. SCHNEEBELI?

Mr. SCHNEEBELI. Dr. Roth, is your proposal to supplement medicaid, replace medicaid, or to supplement medicare? What area does this cover?

People over 65, between 21 and 65?

Dr. ROTH. This applies, Mr. Schneebeli, to the entire population up to the age of 65. It is not our present intention to suggest any changes in medicare.

Mr. SCHNEEBELI. Then it would cover the area that we generally term "medicaid," between 21 and 65?

Dr. ROTH. Yes; title 19 is essentially to be replaced by this program.

Mr. SCHNEEBELI. Do you have any standard proposed coverage under this? Is there proposed coverage that would be standardized throughout the country for this group?

Dr. ROTH. Yes, sir. We speak in terms of a basic package of coverage. We also consider supplements which may be added, depending on the financial feasibility of underwriting them.

Mr. SCHNEEBELI. But there is a basic fundamental—

Dr. ROTH. The basic coverage is 60 days of inpatient hospital care, a figure which we have selected. You will notice that this is less than the 90 days of title 18.

On the other hand, hospital utilization by the under 65 population is substantially less than that of the over 65 group, so that we still are providing roughly nine times the length of care that is represented by the average hospital stay for the under 65.

Mr. SCHNEEBELI. Yours is quite a very comprehensive plan.

You have three categories, those who can't, those who can pay partially, and those in the high-income category. Are there any specific income areas there where they are divided?

Dr. ROTH. Yes, sir. However, we do not in our plan use gross income as your yardstick of ability to pay. We use tax liability because

we feel that it is a better yardstick of ability to pay. I have used the example of two men living side by side in comparable homes having the same salary. One may have many dependents, may have had unreimbursed casualty losses, bad investments, all sorts of financial reverses, while his next door neighbor, who has the same gross income, has none of these. It is obvious there is a difference in the ability to pay, and this is reflected reasonably accurately in tax liability because he has his reductions for dependents and for unreimbursed casualty losses, and so on. We feel that tax liability is the most accurate readily available test of ability to pay.

We arbitrarily selected \$300 of tax liability as being the dividing line between the provision of 100-percent free certificates and participation. Individuals whose tax liability lies between \$300, and \$1,300 would be entitled to take off varying percentages, an inverse sliding scale of percentage, so that, as we have mentioned in our testimony, the chap who has \$500 of liability would get, I believe it is, 70 percent.

Mr. SCHNEEBELI. Going down to 20 percent at the top of that?

Dr. ROTH. It actually goes down to 10 percent on our scale, sir.

Mr. SCHNEEBELI. And then above \$1,300 tax liability would be no reduction? That is your proposal?

Dr. ROTH. Well, we have actually said anyone from that point on up can get 10 percent. However, all he has to do is take a sharp pencil and figure out whether he makes out better under the provisions of the existing law which give him up to \$150 or half of the cost of his premium, or whether he makes out better with the 10 percent. We think most people will make out better with the existing provisions of the law rather than the 10 percent so there is very little use in shutting it off there.

Mr. SCHNEEBELI. Generally, I believe under medicaid we offer general guidelines and the States put in their own program and those State programs vary all over the country.

Dr. ROTH. Yes, sir.

Mr. SCHNEEBELI. This would be a standardized program?

Dr. ROTH. This would be a standardized program.

Mr. SCHNEEBELI. States wouldn't be involved, would they, in the reimbursement to the recipient?

They are under medicaid, I presume.

Dr. ROTH. They are.

Mr. SCHNEEBELI. But under this program the States wouldn't be bearing any portion of the expense?

Dr. ROTH. I think it is an important point. This does not appear in our statement—and I am sorry it doesn't give intimidation of it—but in our costing out of this program, we have felt that there is great advantage in retaining some of the aspects of coinsurance and front-end deductions that are used in medicare. We use them differently for very substantial reasons, I believe, but we do keep in a \$50 front-end deductible on the hospital insurance and we also keep a 20-percent coinsurance for medical fees.

Now, obviously, coinsurance and deductibles have very little practical value when you are dealing with title 19 recipients so that we preserve here a role for the States; our draft bill has a provision whereby States may contract to pick up this \$50 deductible, or the 20-percent coinsurance.

Mr. SCHNEEBELI. But the States' involvement financially would be a lot less than it is at the present time?

Dr. ROTH. Yes, sir; substantially.

Mr. SCHNEEBELI. So the States would be very happy with a program of this type?

Dr. ROTH. I believe State legislators would be happy with this.

Mr. SCHNEEBELI. While they are unhappy with the medicaid program, because it has ballooned so much.

How would the Federal cost compare between your proposal and what probably we can anticipate for medicaid? We certainly don't know what the cost of medicaid is because it has been ballooning all the time, not only because of medical costs but because of changing stipulations and guidelines within the States themselves, but how, generally, would this cost compare, number one, overall, and number two, that incidence that falls to the Federal Government?

Dr. ROTH. Yes, sir. I am sure you recognize that with the number of variables in a plan like this it is about like trying to predict next year's Dow Jones average, but if you will permit me certain basic assumptions, I will try to give you some cost figures.

Mr. SCHNEEBELI. Surely.

Dr. ROTH. My assumptions are important. My first assumption is that we are dealing with roughly 30 percent of the population who might have a tax liability of under \$300 and, therefore, be entitled to 100-percent payment for the certificates.

Our figures are probably obsolete in this respect, but they are the latest ones we could get and they run of the magnitude of 30 percent of the population under this \$300 tax liability, 50 percent of the population lying between \$300 and \$1,300, and 20 percent above this level.

The second assumption is that we are talking about costing out only this basic coverage that we have talked about, 60 days of hospital, and medical services wherever rendered.

And the third assumption is that we are retaining the deductibles and coinsurance which makes considerable difference in costing out an insurance package.

Now, on these bases, we project that the cost for family coverage, and a family by our statisticians has been given the improbable number of 4.6 people, family coverage figures out at \$662.53; for two adults, \$428.78; and for an individual \$219.17.

Mr. SCHNEEBELI. That is the figure that the insurance companies have given us as the cost?

Dr. ROTH. Yes, and it sounds high if you are mentally comparing this to what you may be paying for similar coverage. It is because there is no possibility of selecting risks in this program.

Mr. SCHNEEBELI. But, on the other hand, you have a terrific big broad base.

Dr. ROTH. You have volume, but then we also are using figures as best we can project them to 1970 cost levels. This works out to a cost to the Government for the 100-percent vouchers of a potential \$7.8 billion.

Mr. SCHNEEBELI. \$7.8?

Dr. ROTH. \$7.8 billion for the purchase of the 100-percent certificates.

Now, then, to this must be added the revenue loss from this tax credit mechanism for all of these people between \$300 and \$1,300. This could add up to a possible \$6.8 billion if it were maximally used.

But, then from this, you must subtract an offset in savings to the Federal Government for its input to the title 19 programs. We are using a figure, which, again, is probably obsolete, of \$2.5 billion. So that the net result is a maximum, we believe, cost of \$12.1 billion for full potential use of the program.

Actually, our estimates of a more reasonable level of use reduce this to \$8.3 billion.

Mr. SCHNEEBELI. You didn't include in this people over \$1,300, did you, that 10 percent?

Dr. ROTH. They are included in the revenue loss figure.

Mr. SCHNEEBELI. I see.

So your net cost is between \$8 billion and \$9 billion?

Dr. ROTH. This is our estimate of use, although if it were used by everyone and our figures are anywhere near accurate, it could go up to \$12 billion; yes, sir.

Mr. SCHNEEBELI. \$12 billion, while the present medicaid you said could cost us \$2½ billion.

Dr. ROTH. That is the offset figure that we used and that is the Federal part only.

Mr. SCHNEEBELI. I realize it doesn't include the States, but the States probably about the same, isn't it?

Dr. ROTH. Roughly the same.

Mr. SCHNEEBELI. So that is about \$5 billion compared to your \$12 billion?

Dr. ROTH. Yes, sir.

Mr. SCHNEEBELI. This would come out of general funds of the Federal Government?

Dr. ROTH. Yes, sir; completely.

Mr. SCHNEEBELI. This is quite a sum of money.

Dr. ROTH. It certainly is.

I would point out that we have been unable to find any way to provide this volume of services without it amounting to a substantial amount of money because it is the services that are expensive, not the system under which they are provided.

Mr. SCHNEEBELI. At the time that this committee considered title 19, medicaid, do you recall whether anybody proposed a suggestion such as you have here?

Dr. ROTH. It was not proposed.

Mr. SCHNEEBELI. This is quite new, is it not?

Dr. ROTH. There have been previous bills in Congress, as I recall, which used some variant of the tax credit mechanism. I think Mr. Bow had a bill which used this approach.

Mr. SCHNEEBELI. This is rather minimum coverage, too, you said, without any additional supplement. This is pretty basic, 60 days compared to 90 days. It is not a big blown up health plan. It is rather minimal, is it not? It is something from which we could expand later. Usually when we introduce a program it is pretty basic and fundamental and then we add features to it thereafter, so the cost of \$12 billion would be an initial basic minimum cost and it could go up anywhere from there?

Dr. ROTH. Yes, sir, Mr. Schneebeli. I believe that this is as modest a program as we still can in good conscience call comprehensive.

Mr. SCHNEEBELI. And this is based on medical costs as of what—as of today, or as projected, or what?

Dr. ROTH. This is based on a projection of 1970 costs.

Mr. SCHNEEBELI. 1970 costs?

Dr. ROTH. Yes, sir.

Mr. SCHNEEBELI. So by 1975 this program, we anticipate, could go up 20, 30 percent minimum?

Dr. ROTH. I believe that our association unhappily agrees that medical care costs are destined to increase, especially as progress is made in what you are able to do for people, and things to do it with.

Mr. SCHNEEBELI. The American Medical Association in the past has been known for being not only conservative but very concerned as to the Government involvement in medical expenditures and here we have a program at a minimum cost of \$12 billion compared to the present Federal cost of 2½ billion or total Government cost, of \$5 billion. This is quite a departure for the American Medical Association to take, based on past history.

Dr. ROTH. I believe, sir, that this is testimony to the fact that the American Medical Association has flexibility and adaptability. Lord knows, we have to adapt to progress at the scientific level and I think we are also able to adapt at the socio-economic level.

Mr. SCHNEEBELI. Which is quite a change in philosophy in the last 5 years.

I am not objecting to it. I merely remind you that it is quite a change of position.

Was your proposal approved by the whole American Medical Association?

Dr. ROTH. The first opportunity that our policymaking body, which is our house of delegates, had to consider this and act on it was roughly a year and a half ago at an annual meeting in San Francisco.

Mr. SCHNEEBELI. And it was approved at that point?

Dr. ROTH. Yes, sir; enthusiastically, I may say; together with a mandate to us to try to get this into form to be considered for actual legislation as rapidly as possible.

Mr. SCHNEEBELI. Were the cost factors available at the time it was enthusiastically recommended?

Dr. ROTH. We employed outside actuaries we believe to be competent in this field to respond to our request for costing this thing out and this material has been generally available. It has changed as we have changed a bit the character of the package. We considered many things. This is a distillation of it.

Mr. SCHNEEBELI. At the time it was approved by your house of delegates were the figures that you just gave to me available to your group.

Dr. ROTH. The figures that I have just given to you as such were not available.

Mr. SCHNEEBELI. Were not available? Was it within the ball park in correct estimate? Was it close to the figures that you had for their approval?

Dr. ROTH. We had the basic figures of the cost of the package to families, two adults, and individuals, essentially as I have given them to you.

Mr. SCHNEEBELI. Thank you very much, Mr. Chairman.

Mr. BURKE. Dr. Roth, the AMA has always been opposed to compulsory health insurance. Is that correct?

Dr. ROTH. Yes, sir.

Mr. BURKE. And yet your plan would be a compulsory tax, so how do you justify the inconsistency here?

Dr. ROTH. I would not feel, Mr. Burke, that there is an inconsistency. I believe you get into a semantic problem in dealing with the under-income people, those for whom title 19 or other welfare programs have always provided and must provide. I think that when you are giving somebody something for free, which is essentially what we are doing with our 100 percent certificate, it becomes academic as to whether this is compulsory or voluntary. I presume nobody has to take it if he doesn't want to.

Mr. BURKE. What I am referring to is not the voluntary health side of it but the taxing side of it. You are making it compulsory on the tax. This is a compulsory feature of your bill.

It seems to be somewhat inconsistent. In one place you don't want the Government having compulsory health insurance and yet, on the other hand, you are advocating a compulsory tax here which, to me, seems to be a little bit inconsistent for your organization, having listened to it for the past 10 years.

Dr. ROTH. Well, sir, I am obviously not prepared to answer this. I think that we as an association have not looked upon this as having the elements of compulsion, to which we object. I am sure there is a certain amount of compulsion in all taxation.

Mr. BURKE. The compulsion is on the tax end of it, not on the health care, and it seems to me that you are a little bit inconsistent here, that you are coming in recommending a health plan which is entirely dependent upon a compulsory tax in order to finance it.

Mr. HARRISON. Mr. Burke, are we speaking to just the income tax laws as being compulsory?

Mr. BURKE. Well, it is quite apparent here from the Doctor's statement that there will be a cost of about \$8 billion up to \$12 billion to put this plan through and in order to put it through we will have to have some kind of a tax and that will be a compulsory tax upon the American citizen to pay for this plan.

Mr. HARRISON. The American Medical Association has never taken a position, Mr. Burke, with respect to the income tax as such or recommending or advocating that the income tax be repealed. It recognizes full well, as do I am sure most all our citizens, the requirements of Government to finance and fund the very many programs in which the Government is engaged. The Compulsory features of the income tax law are really not under question here. We are suggesting that the income tax law be amended, in effect, to provide another mechanism of allowance or credit to support a program of voluntary health insurance or to provide incentives for voluntary health insurance.

Inasmuch as it is funded out of general revenues, and those moneys are in the main received from taxes, there is, then, that compulsion to pay taxes and, in effect, to provide the necessary funds for this program. But that is the same as for any other program that is funded through the general revenue.

Mr. BURKE. So the facts are, in spite of all your testimony down through the years, you people favor a health insurance plan with compulsory features on the tax end of it.

Mr. HARRISON. No, that is not correct, Mr. Burke. We do not favor a compulsory health insurance program. This is a program that contains an option for the individual with incentives to purchase or to acquire health insurance coverage. We believe that the voluntary health insurance mechanism is the approach that is best suited to this country. We believe that very firmly.

Now, the program will be financed through general revenues and we acknowledge, as does everybody else, that general revenue funds are, in the main, accumulated by the Government through the income tax laws.

Mr. BURKE. I don't want to belabor the point.

What would be the required basis for paying for physician's services under your bill?

Dr. ROTH. This, we believe, is an extremely important part of our entire program. We feel that the medical profession over many years has demonstrated good conscience in its charging procedures. The profession set up peer review and control mechanisms, claims review, and utilization review, which was being established long before the advent of medicare, but which has been given great impetus by the medicare law. I think it is significant to remember back to the early days of the old original medicare program for the dependents of the Armed Forces. At that time there was governmental insistence on negotiation with each State of a fee schedule, but we did have one State that objected to publishing a fee schedule. As I recall, it was Indiana. They negotiated a fee schedule, but they never published it. Indiana physicians were allowed to submit their charges to the program just as they had always submitted charges, and the interesting thing was that the Indiana experience under this system ran—well, under 80 percent of the negotiated ceiling. In all the other States where the fee schedules were published, it became a guide to physicians as to what they were really expected to charge, or so they interpreted it, and the charges went up to virtually 100 percent. The ceiling became indistinguishable from the floor.

Now, we feel that the pressure upon physicians to adhere to certain administratively proposed guidelines, rules, and regulations substitutes a uniformity of fees rather than to allow services to be dictated by the doctor's conscience.

We would rely on the experience that has accumulated in the health insurance industry and the voluntary plans on what going rates are, what reasonable fees are, and what usual and customary fees are. We would propose that it be the responsibility of the provider organizations, the medical societies, together with the insurance carriers, underwriters, to monitor this, to pick out departures from defensible levels, and to use peer review to adjudicate these. We really feel that the involvement of the medical profession, the fact that the physicians have sponsored, approved, this plan gives them a vested interest in its success. This is their chance to demonstrate that they can provide medical service at reasonable fee levels. We feel that the acceptance by the medical profession of this responsibility is far greater than under any plan where there is a tendency of the physician to shrug off this responsibility to Government or to some third party agency.

Mr. BURKE. Would doctors still treat the person who didn't choose to participate?

Dr. ROTH. Pardon me?

Mr. BURKE. Would doctors still treat the person who didn't choose to participate in the program?

Dr. ROTH. Oh, yes, sir, I am sure they would.

Mr. BURKE. Do you agree with the statement made by Dr. Durward Hall inserted in the Congressional Record on May 5, 1969, when he stated, "The annual increment rate of physicians' fees has gone from 3 percent, perhaps due to a combined fear of schedules, the 'floor' and in many cases—pure gluttony, have bungled the relationship with American nurses."

Dr. ROTH. I am sure that there have been instances of indefensible practices on the part of physicians. These have been given a great deal of publicity. I am equally sure that this represents a minute segment of our profession. I am equally sure that when the title 18 and title 19 programs came into being they forced upon the physician some attention to and standardization of his fees which he had rarely thought of before. When he picked the standard fees he obviously was looking around to see what his neighbors, his colleagues, were doing, and this had the effect of escalating the overall level of fees in the beginning. I trust that this rate is not going to continue.

Mr. BURKE. Do you know of any endeavor in our American life where the fees have been raised and escalated to such a high point as in the medical profession during the past 5 years? Is there any area at all that you know of where the costs have gone up, pyramided to such heights?

Dr. ROTH. It is my totally undocumented impression that the expenses, costs to the consumer in other areas are going up equally high. I would be unable to document it.

Mr. BURKE. Would you mention one of them?

Dr. ROTH. Building trades, sir.

Mr. BURKE. The building trades have gone up as high?

Dr. ROTH. Construction, the cost of construction.

Mr. BURKE. Can you document it?

Dr. ROTH. No, I cannot document it. I can give you simply impressions from things I have read. I picked the cost of constructing office buildings because of an article in the Wall Street Journal within the last 2 weeks which seemed to indicate that this is going up immensely and the cost of floor space rentals in office buildings are going up immensely, at percentage figures which I believe to be above the medical care component of the consumer price index.

Mr. BURKE. Have you read the Senate staff data relating to the medicaid and medicare study—

Dr. ROTH. That does not look familiar.

Mr. BURKE (continuing). Of the Committee on Finance of the U.S. Senate?

Dr. ROTH. I have not read that, sir.

Mr. BURKE. Would you be interested in chart 13, which shows the consumer price index for physicians' fees in 1962 went from 112 in 1962 up until 1968 to approximately 145 in 1968. Would you say that was a rather rapid rise?

Dr. ROTH. That sounds so.

Mr. BURKE. Would you say it was an unconscionable rise?

Dr. ROTH. I would not say that, because I would need to know a lot more about what has happened to the other indices. How about the hospital index?

Mr. BURKE. It seems everybody connected with health care is in the act, but it does seem that the physicians' fees and hospital costs have really pyramided, and one wonders why, whether it is greed, avarice, or whether it was actually needed.

Dr. ROTH. Well, Mr. Burke, I would freely admit that our association agrees that to the extent that this is the element of it, it may be unconscionable or indefensible and we need to control it. We have seriously considered various proposals to control it and we feel that the medical profession itself through peer review has the best opportunity to do this. No one has devised any better means of doing it. The insurance industry has depended upon it. The Government itself in medical programs that it sponsors has depended on peer review. We need your help and the help of Government in perfecting peer review and its application because there is really no capacity for any other element or force within our society to do this that we can see.

Mr. BURKE. And you believe that under your bill this tendency towards greed and avarice will end and that the cost will level out?

Mr. HARRISON. Mr. Burke, I would like to comment on your use of the terms "greed and avarice." I think that they are a most unfortunate choice as far as terms are concerned. If you are speaking about individual cases that may be found across the country, we would perhaps acknowledge it with you. Certainly those situations exist in this profession as it may in others or in other endeavors. But we think that this is an unfortunate choice of words if you are reflecting upon the medical profession as a whole.

I think you indicated a rise in the consumer price index over a period——

Mr. BURKE. I am not making a blanket indictment. I am merely pointing out——

Mr. HARRISON. I am glad to hear that, Mr. Burke, because I thought that was——

Mr. BURKE (continuing). The height these costs have risen to, and certainly there must be some people connected with the AMA that have taken advantage of the public.

Mr. HARRISON. There probably are and there are few instances——

Mr. BURKE. Not probably. There are.

Mr. HARRISON. We have some 300,000 physicians in the country and I think the instances would be relatively small in number. I think it is most unfortunate if we attempt to use the terms "greed" and "avarice" and relate those to the profession as a whole. In the main, we have a relatively smaller index of an increase.

Mr. BURKE. Just a moment. What does your organization do to stop this avarice and greed that I have referred to?

Dr. ROTH. Mr. Burke, I think in the medical profession there has probably—traditionally, over the years—been less evidence of greed and avarice than in almost any other profession I can think of, and I would possibly exclude the ministry. Actually, dollars are not an important element as far as the motivation of a physician is concerned, and this is almost an unhappy fact of life right now. It accounts for part of our problem. It is why we have so many physicians involved in

what I would call a flight from practice and particularly a flight from general practice.

I can cite you in my own experience dozens of examples. I run a residency training program in urology and I am amazed to have general practitioners coming in wanting to go through 3 or 4 years of austerity in a special training program. They are leaving a relatively lucrative general practice to do this. You ask them why and the answer is not money. It is that they want respite from the pressures of the demand that is placed on them. This is why they are leaving the rural towns. This is why doctors who are in general practice are going into administrative medicine, into teaching, into research, almost anything, to preserve for themselves a few hours of free time and some time for their families.

I have seen this. I also happen to be the chairman of a county department of health and we have been trying to recruit a qualified health director. I have been amazed to have applicants among young general practitioners who come by to see if they are qualified to take this job which will pay them substantially less than they can make in private practice.

Actually, there is other testimony to this. In the last 5 years, we have had additional billions of dollars pumped into the economy of health care industry and yet it has not provided the answer or incentive for physicians to get out and fill these general practice spots. We still have an overwhelming majority of our young graduating physicians going into specialty training rather than into general practice. Dollars are not the answer and the medical profession is not an avaricious or greedy profession.

Mr. BURKE. I didn't mean to make a blanket indictment. I made an indictment against those people who have pyramided the costs as high as they have. I would like to ask, what is your organization doing about setting up medical services in some of the poor areas of our country?

I listened to a program the other night about an area down in Mississippi where Howard University is attempting to create a medical school and create some facilities there that will help relieve the problems that they have in those areas.

What is the AMA doing specifically in these areas?

Dr. ROTH. Well, let me give you a few specific examples. We have been involved in the State of Missouri, in the Kansas City area, with assistance to, and actual dollar assistance to a poverty program which was originally stimulated and designed by the students there, the Student American Medical Association. We currently have under favorable consideration participation with Temple University in a community health program, which I believe is two-part in character, operating there. We have relatively recently established a top level board of trustees, Committee on Health Care for the Poor that has had its own committee meetings on a number of occasions. It has brought in as consultants the directors of some 21 of the outstanding more successful operating programs in this area—from Watts, Willowbrook on through to Columbia Point in Boston. It then had a second session in which consumer representatives, representatives of the poor themselves, were invited in to provide their input. We believe we have an active, ongoing involvement which is inevitably going to be limited. The requests for support and assistance are numerous.

Our capacity to devote funds to these projects are limited. But we are actively involved—since we are not a service organization—in the planning and facilitation of these programs.

Mr. BURKE. What proportion of the total income of your association do you spend on these activities?

Dr. ROTH. Very small at the present time. I could not give you a precise figure, but it is minimal, Mr. Burke.

Mr. BURKE. Practically insignificant, is it not?

Dr. ROTH. I would so regard it.

Mr. BURKE. Thank you.

Are there any questions?

Mr. LANDRUM. Dr. Roth, along the same line of the colloquy you just concluded with Congressman Burke, I have noted all of the many things the the American Medical Association and the local associations over the country are doing to try to get professional services down to the level of the so-called poverty group, and I have noted, also, the tendency that you recited there of the young doctors to leave the general practice of medicine, and particularly the general practice, as it must be carried out in the smaller towns and the rural areas and I wonder why the American Medical Association doesn't launch some sort of a campaign to enlarge the student body at the various university medical schools.

I can appreciate why you would need to perhaps restrict sharply the student bodies, at the privately endowed institution that was supported by private funds, but it has been my experience that when the public need becomes so evident, as it has become in this area, that you would have no great difficulty getting the public funds to support the expansion of the State medical institutions, the State universities.

I wondered why your association doesn't do more in this field?

Dr. ROTH. Well, sir, I believe we are doing a great deal. Of course the American Medical Association has been charged on many occasions with somehow or other controlling and constricting the production of physicians, but I think that since 1910 or 1915 this has not been true. I will admit if anybody wants to bring it up that the result of the Flexner Commission report on standards of medical education, which was aided and abetted in implementation by the American Medical Association, had the effect of reducing the number of so-called medical schools in those days and getting down to a hard core of schools that were really providing medical education.

Since that time, I think the American Medical Association has done nothing but work to augment the quality and quantity of medical education up to the present time. I hope you are aware that the American Medical Association and the Association of American Medical Colleges have agreed on a fundamental policy of increasing the number of available spots in medical schools so that no qualified applicants may be turned away for lack of the opportunity for training.

Now, there has been a substantial increase in the number of medical schools in the relatively recent past.

This fall we have opened our 101st medical school in this country and, in addition, there has been something of the magnitude of a 10-percent increase in the size of classes which is, therefore, equal to opening 10 more schools.

We are, at the present time, increasing the physician population at a faster rate than the overall growth of the population but we still aren't keeping up with demand. We still have not answered the problem that you are talking about, getting practicing physicians into the rural, and not necessarily rural poverty areas, just rural areas.

Mr. LANDRUM. Just rural areas.

Dr. ROTH. And the poverty areas and the ghetto areas. As we study this, we are convinced that there is far more to this problem than simply a matter of dollars or a matter of poverty.

Mr. LANDRUM. As a matter of fact, Dr. Roth, your so-called poverty areas are more heavily concentrated today in the metropolitan areas than they are in the rural areas, as you well know. In the rural areas today, except for the fact that we find it difficult to get qualified physicians, surgeons, doctors into the area where they live, we are a lot better off than you are in Pittsburgh and up in that area or my folks down in Atlanta are.

Dr. ROTH. You are absolutely right, sir. Let me point out that in many of our metropolitan areas, and in pretty much the heart of some of the ghetto areas, we have some fine medical institutions offering medical care and people living in the very shadow of these institutions do not take advantage of them. It is not a dollar barrier because the other barriers standing between the person who needs medical care and the person capable of providing it may be harder to pull down than the poverty barrier. These are the barriers of ignorance, of fear, of superstition, of misplaced faith in nonscientific alternatives to medical care. These require the efforts not so much of the physician alone, but of educators and sociologists. I believe that some of our ghetto projects that have been developed in recent years, the work of Dr. Jack Geiger and Dr. Count Gibson, have shown that we really have to develop almost a new kind of physician, a specialty as yet unnamed, who will move into these areas and study the background, the mores, the racial superstitions, and problems of education to get the confidence of people to overcome the fear element and ignorance element to get these people in for services that are freely available.

Mr. LANDRUM. I am glad to see one with such an outlook as you have as a speaker of the house of delegates of this great organization, and I, too, hope your organization will devote more of its activity, more of its effort, toward influencing young qualified people to come into general practice and in the rural areas, or relatively speaking rural areas.

Dr. ROTH. You will be interested to know, sir, that we have finally given status to a specialty which is now called family practice as against general practice or whatever it used to be called. There is now status which is important in any medical area. The general practitioner used to sort of feel that he lacked status because he had no specialty qualifications. Now he may have them.

Mr. LANDRUM. Now, I want to get over just briefly to the cost area that you were discussing with Mr. Schneebeli.

I believe that in taking your assumptions and evaluating or estimating what the costs would be, you said 30 percent of those would have a tax liability of \$300 or less, 50 percent in between \$300 and \$1,300, and 20 percent above \$1,300. We are talking about tax liability.

Dr. ROTH. Yes, sir.

Mr. LANDRUM. In taking the assumptions that you took and arriving at the figures that you did arrive at, did you take into account the fact that the tax reform bill of this committee and the tax reform bill reported out of the Senate last Friday excuse from any tax liability—how many millions of persons.

Mr. SCHNEEBELI. Five.

Mr. LANDRUM. Between 5 and 8 million people entirely? They are not taking the \$300 figure. They are a gross income figure where the Senate bill, as I recall on Friday said a single person with \$1,700 or less files no tax report at all, a married couple with \$2,330 or less files none, a family of three with \$2,900 files none, and on up to about \$3,400. Did you use any of that potential in estimating your cost?

Dr. ROTH. The figures which I gave you were drawn up last May, sir, and had none of this input. However, we have been aware of this and I have asked the questions of, I hope, knowledgeable people, how much impact, how much skew this would give to our figures. The general feeling is, my information is, that the overwhelming bulk of the people who have been excused from any payment of taxes had less than a \$300 tax liability and, therefore, would not change our figures substantially.

Mr. LANDRUM. Now, your recommendations are for the replacement of the medicaid program, as I understand them.

Dr. ROTH. Yes, sir.

Mr. LANDRUM. And you make no recommendations with regard to amending or replacing the medicare program?

Dr. ROTH. No, sir. We are not changing it. It would have some impact on the individual patient who is covered by medicare only to the extent that as that individual pays his currently \$4 a month which we understand is going to be up substantially next year—

Mr. LANDRUM. Can we assume, Dr. Roth, that the course you are taking before the committee today is an endorsement of the medicare program?

Dr. ROTH. I believe it would be fair to say that the American medical profession has lived more comfortably with medicare than they expected to.

Mr. LANDRUM. One other question, please, sir.

At the time we were developing what is now known as medicare we had considerable discussion and debate surrounding this medicaid element of it, also, and I believe the American Medical Association at that time came forward with a recommendation under the label of eldercare or something of that kind.

Dr. ROTH. That is correct.

Mr. LANDRUM. Tell me, please, sir, what is the chief distinction, if there is any distinction, between eldercare as you recommended it, medicaid, and this program you now recommend?

Dr. ROTH. Yes, sir. Eldercare, and I am delighted that somebody remembers eldercare usually we are accused of having been totally against providing Federal help for the aged—

Mr. LANDRUM. I am not making any accusations in that statement.

Dr. ROTH. I know you aren't.

Mr. LANDRUM. I am just merely asking for a comparison between what is now medicaid and eldercare and what you now recommend.

Dr. ROTH. As I say, I am delighted to know that this has remained in the memories because this indeed was the American Medical Asso-

ciation's methodology for providing substantially the same kind of health to older people that the medicare law actually provides. The basic difference were two in character. The eldercare proposal would have geared its support to need. We did not give a blanket coverage to the wealthy, the moderately well to do. This, too, was geared to individuals who had by some yardsticks demonstrated economic troubles.

The second major difference is that the eldercare was not financed through an extension of the social security system.

Now, eldercare differs substantially from our new program, well, in the obvious area of its applicability to beneficiaries. Eldercare talked about over 65. Our current program talks about under 65. Our current program, however, shares with eldercare the absence of the use of the social security financing system. There was no tax credit element in eldercare. I don't know whether that answers your question or not. There are those differences.

Mr. LANDRUM. Reasonably so.

Thank you, Mr. Chairman.

Thank you, Doctor.

Mr. BURKE. Mr. Byrnes?

Mr. BYRNES. Doctor, I appreciate very much your testimony. There is one aspect that I wondered if you grappled with and that relates to those cases where you have employers subsidized in health policies; for instance, you have it in a lot of union contracts. You have it here in the Federal Government as far as civil service employees. There is a subsidy for medical insurance. How would you gear that into your plan that seems to be entirely related to the individual taxpayer?

Dr. ROTH. Extremely important, Mr. Byrnes, and a great deal of thought has gone into gearing this to just precisely that problem. Actually, let me start by saying that the American Medical Association is in favor of group insurance coverage. It is the most economical kind of insurance and we favor this and we have tried to be very selective in our provisions in order not to interfere with this.

We have, for example, constructed our curve of the credits with particular attention to the avoidance of any point where the individual employee or his union or anyone else might get out a sharp pencil and figure it would be to his advantage to ask for a cash wage increase rather than to broaden medical insurance protection. We believe this is in the bill.

There is another, perhaps not apparent, point as you read my testimony to date, until you have a chance to look through the bill and analyze it in particular, but please remember we are talking about insurance coverage which is not first dollar coverage.

By and large, labor in this country has gone wholeheartedly for first dollar coverage. By and large, the voluntary Blue Shield-Blue Cross provide first dollar coverage. We have a \$50 deductible on hospital and a 20 percent coinsurance up to \$500 worth of medical expenses. This one feature would indeed in many instances militate against an enthusiasm for employees for our package as against what may be provided in collective bargaining and we do not make any effort to give the employer any tax break on this. It is only the employee's contribution in the case of contributory plans that is subject to the credit. So we have taken this point into consideration. If there are other points, we will welcome the advice of this committee, of the insurance industry, and the tax experts.

Mr. BYRNES. This seemed to me to be one of the complicating aspects. Let's take a Blue Cross-Blue Shield policy that has a first-day coverage. Your standard policy here would have a deductible?

Dr. ROTH. Yes, sir, for the hospital.

Mr. BYRNES. For the hospital, all right.

Under that, then, the employee would not be able to get any credit for those premiums that he paid?

Dr. ROTH. Yes, he will, sir.

Mr. BYRNES. On a policy that didn't have a deductible? Maybe I am getting into minute details here, but it does seem to me it is a question of how you gear this into the insurance coverage that currently exists in the country.

Dr. ROTH. Policies in general which are equal to or more comprehensive than our basic policy, I think, would inevitably be approved policies and, therefore, the employee contribution, that part which he actually puts out from moneys due him, would be eligible for tax credit.

Mr. HARRISON. Mr. Byrnes, our suggested draft of the proposal does provide for supplemental benefits which may be added to the package. One of the benefits could be coverage with respect to the deductible or coinsurance. Just on the face of your example, it would appear to me that such a policy would be eligible for the tax credit. The employee's contribution, then, would be eligible for the same tax credit based upon the sliding scale we provide relating to his tax liability.

Mr. BYRNES. In other words, your sliding scale is the mechanism that you use to gear this program into the already existing industrial policies and group policies that exist and are subsidized by the employer?

Dr. ROTH. Yes, sir. If you take the trouble to plot out that scale of ours which runs over two pages in the bill, you will find that it is not either a straight line or a smooth curve. It is a skewed curve of which comes down rather abruptly, plateaus, and then goes back down. The explanation for this is our effort to take into effect the very problem you are talking about.

Mr. BYRNES. Thank you very much.

Mr. BURKE. Mr. Fulton.

Mr. FULTON. Thank you, Mr. Chairman.

Dr. Roth, I want to compliment you on your testimony and presentation today. I think it is a very realistic and humanitarian approach to a problem that we are all aware of.

Also, on the question which was directed to you with reference to the high increase in the cost of medical services over the past several years, I happen to have with me this morning a copy of a recent publication which gives the cost of living increases in several areas from September of 1968 through September of 1969.

The cost of living has gone up 5.8 percent; food costs, 5.9 percent; housing, 6.8 percent; clothing, 5.3 percent; transportation, 3.4 percent; health and recreation combined, 5.6 percent; and services, 7.4 percent.

I thought that should be made a part of the record.

However, I am aware that there are instances where there have been some rather gargantuan increases in the cost of medical services, but just as possibly you have stated, I thought these were the actions of only

a few. Congress has found it necessary also to have an Ethics Committee, which also has difficulty with some Members of Congress.

In the first day of this session of Congress it was my privilege to introduce a bill, H.R. 19, which is very similar to the bill that I understand that you have presented today.

Dr. ROTH. We are well aware of that.

Mr. FULTON. I later introduced a modified version as H.R. 9835.

I would like to think that this approach of tax credit is just following along the lines of the tax reform bill that we just recently passed in the House.

Dr. ROTH. You are completely entitled to take that viewpoint, sir. We have been delighted with the input of your bills.

Mr. FULTON. As to the estimated cost that you have, from \$8 to \$12 billion, based upon many of the contingencies, the elimination of the medicaid program of course, as you pointed out, is a saving of some \$2 billion to the Federal Government, as well as some \$2 billion to the State governments.

We are all aware that the State governments are looking more and more toward Washington for assistance in meeting the needs of the States. Even now being proposed is a tax-sharing plan with the States.

Certainly the adoption of this program would give some additional relief to the States that do not have the additional money to meet these problems.

Have you taken into consideration what it would mean for local governments as well as State governments in the reduction of the care for the indigent that they presently are having to serve?

Dr. ROTH. The reduction of the costs of the care for the indigent?

Mr. FULTON. Yes, sir.

Dr. ROTH. Yes, sir. We would hope that it would in no way decrease the volume of the care, but the cost would in large part be lifted from local government budgets, although we have included some participation, possibly, in respect to the deductibles in coinsurance.

But, you see, one of the reasons for the dampening of our original enthusiams back as far as the Kerr-Mills program and title XIX, which we espoused in principle, has been that to work, it requires adequate implementation, which has not been forthcoming through all 50 States and four other jurisdictions. It requires adequate funding, which has not been forthcoming.

So that when we talk about title XIX programs, we are talking about quite a motley collection of plans. There are still eight jurisdictions in which I believe there is no formal title XIX program. There are others where there is a program, but the benefits are very small and constricted compared to what we call comprehensive coverage, and, therefore, in the absence of implementation and funding, we have felt that it is necessary to do something. The problems in implementation and funding have largely been at the State and local levels, and therefore we attack this weakness in our proposal.

Mr. FULTON. I will not take but just a moment. Mr. Schneebeli has asked a number of questions that I was prepared to ask.

Just to summarize your approach, the intent or purpose is to bring about a financial mechanism for the medical care for all of our citizens, I believe.

Dr. ROTH. Yes, sir.

MR. FULTON. That is, those who would not be covered under medic-aid, and it would be contrary to some of the proposals of other organizations.

It would be on a volunteer rather than a compulsory basis, and the carriers of this medical insurance would be private carriers, rather than the Federal Government, and also, under your proposal, I believe it would be administered by a State insurance board, with Federal supervision.

DR. ROTH. The Federal supervision would be limited to guidelines or requirements, standards, to which the States would have to conform for approval of policies and coverage. But basically we have the insurance industry still dealing with State insurance commissioners and commissions, as they have traditionally done their business, and which they are used to, and with which they are, I think, reasonably comfortable.

MR. FULTON. Dr. Roth, I want to thank you again for your appearance before the committee, and the contribution that you have made to the deliberation on this most important matter.

DR. ROTH. Thank you, Mr. Fulton, for your contributions to this same effort.

MR. BURKE. Mr. Conable.

MR. CONABLE. Thank you, Mr. Chairman.

Doctor, I want to grasp the stinging end of the nettle, here, and talk about something which you have not mentioned, but on which I would like the view of your organization, and that is chiropractic.

I understand the history of the relationship of the medical and chiropractic groups, and I am wondering if there has been any evolution at all as a result of the licensing of chiropractic by most of the States.

I might tell you that my own position was that I voted against the licensing of chiropractic in New York State when this was up before the legislature some years ago and nobody could call me, historically, anyway, a friend of chiropractic.

But of course the purpose of licensing chiropractic was to upgrade it, and we find ourselves in a very strange and unstable position which has left Congress right squarely in the middle of a dispute between the two groups. Chiropractic is acknowledged and permitted to perform services under medicaid, but not under medicare. Frankly, it has not made a great deal of sense to have this situation. Those who, because of their circumstances, can claim health services under title XIX, who contribute nothing to the funding of the program, but because of their impoverished state are eligible, can elect to have chiropractic services, while those who contribute voluntarily under plan B of title XVIII cannot elect to have chiropractic services.

Now you see that this puts us in Congress in a rather strange position, where we are furnishing public funds for the treatment of people by chiropractors under title XIX, but not permitting those who contribute themselves to elect to have chiropractic.

I call this an unstable position, because it is illogical, and it is inevitable that we in Congress are going to be under great pressure from those who believe in chiropractic to include it also under title XVIII, as well as title XIX, as long as this condition exists.

I am a layman, and I am not knowledgeable about the various disputes between these two branches of the healing arts, but I am in-

terested in whether or not there has been any revision of the relationship between the two groups as a result of the widespread licensing, most of which was directed at upgrading chiropractic as a healing art, and basing it on what at least from a medical viewpoint is a sounder basis than many people felt chiropractic had when it was unlicensed, when there was no public concern about the qualifications of those practicing chiropractic.

This is a complicated question, I realize, sir, and it puts you in a delicate position to answer it, I am sure, but I, as a layman, would be interested in your response. I do feel that we here in Congress are in the middle of a comparatively irreconcilable contradiction in our public health programs.

Dr. ROTH. I would hope it is not an irreconcilable contradiction, Mr. Conable, I have no hesitation in suggesting that the American Medical Association, and I would say overwhelmingly, perhaps every one of its members, would subscribe to the remedy which we would propose. We indeed feel that your program should be consistent, and consistency should be achieved by eliminating payment for chiropractic from all of it.

I would only point out to you that there has been a magnificent eclectic track record for the medical profession in this county, and elsewhere in the world.

I think that none of you gentlemen would harbor in your minds for one moment the thought that if the magnificent departments of medicine and surgery of our Army and our Navy and our Veterans' Administration felt that chiropractic had one thing to offer to the well being of our wounded servicemen and our sick and disabled servicemen, they long ago would have ignored any other considerations except the welfare of their patients. Yet they have never accepted chiropractic services.

I think there was an excellent study made by the Department of Health, Education, and Welfare on independent practitioners under medicare, which recommended a perfectly proper answer, which we of the American Medical Association would support 100 percent.

May I read just one key paragraph from this:

"Chiropractic theory and practice are not based upon the body of basic knowledge related to health, diseases, and health care that has been widely accepted by the scientific community. Moreover, irrespective of its theory, the scope and quality of chiropractic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment. Therefore, it is recommended that chiropractic service not be covered in the medicare program."

I believe that we would wholeheartedly extend this to the point that it not be included in any other federally financed program. We believe this is an opportunity for two benefits: A savings of Federal dollars, and an improvement in the overall health care, since chiropractic is one of—I don't even want to use the word—the disciplines that I have grouped under nonscientific substitutes for scientific medical care.

Mr. CONABLE. How do we reconcile this with the licensing of chiropractic by the States?

Dr. ROTH. I come from the State of Pennsylvania, where this was long and bitterly fought over a number of years, and all I can say is that the guys with the white hats lost.

Mr. CONABLE. But apparently they have lost generally if chiropractic is licensed in most of the States.

You understand our position here, don't you, sir?

Dr. ROTH. I do.

Mr. CONABLE. That we are in what could be described as a delicate position, as a group of laymen trying to evaluate the claims of not only the professions, but our constituents, many of whom are outraged by the fact that they cannot get chiropractic services, in which for one reason or another they believe—

Dr. ROTH. They like their chiropractors.

Mr. CONABLE (continuing). Under a program to which they contribute, while they can get those services if they are just poor enough so that they cannot contribute to the program.

Dr. ROTH. We appreciate your problem, and we have seen many State legislatures in the same problem, and we hope you come out better than most of them have.

Mr. Harrison would like to add.

Mr. HARRISON. We understand the pressures which are involved, and I think this morning you are going to hear some of those pressures with respect to the addition of chiropractic services under medicare.

When you speak with respect to your constituency in the medicare program, the constituency generally is the people over 65, with the interests of the public at large. I think the people over 65 are best represented by the National Senior Citizens Council, a very large organization, with millions of members. I am sure that the group has been before this committee on many occasions.

Actually, we have not always seen eye to eye with respect to their recommendations with respect to the best way to provide health care for the public. Their recommendation is:

"Chiropractic treatment designed to eliminate causes that do not exist, while denying the existence of the real causes, is at best worthless, and at worst mortally dangerous."

This is the statement of the Senior Citizens Council, a published statement, an organization representing millions of senior citizens, most of whom are under the medicare program. The senior citizens themselves have undertaken a campaign through their newspaper with frontline headlines, and so forth. I would be glad to provide the committee with copies of their communications as well as a copy of the Independent Practitioners Study under medicare, which was a study undertaken by the Department of Health, Education, and Welfare, and one where the American Medical Association did not testify before the group involved, though we sought an opportunity to do so. This was an independent study made.

So that when we are speaking as to chiropractic and the problems of the constituency, we ought to look to the people involved in the program, those over 65, and they themselves say that at best chiropractic is worthless, and at worst it is mortally dangerous.

I think perhaps this committee might view an obligation that it may have with respect to—rather than broadening medicare to include chiropractic, which of course should not be done under any circumstances—consider amending the title XIX program so that the chiropractic service cannot be provided under it, inasmuch as this is really a health quality question and not a question of cost.

Mr. BETTS. Mr. Chairman.

Mr. BURKE. Mr. Betts.

Mr. BETTS. I just want to follow through with what Mr. Conable said.

I am not in a position to sympathize with either the medics or the chiropractors, but it does not seem to me that you have taken us off the hook, because the fact still remains that States license chiropractors to practice the healing arts.

Maybe this is a way of getting off the fence we are on, but it always appeared to me that it was asking a great deal for the doctors to say that we should not include chiropractors, and asking a great deal for the chiropractors to say that we should include them, because after all we are a taxwriting committee, and for us to sit here and say who should or should not practice the healing arts I think is a little beyond our authority, here.

I have sort of thought, and I guess I am the only one on the committee that thinks this way, that in the historic concept of separation of State and Federal responsibilities we have left this up to the States, and that about the only way out that this committee has is to recognize who the States allow to practice the healing arts up to the extent that they allow them.

If they say somebody should practice Christian Science, that is the State's business, not ours. If they want to practice on feet and trim the corns and ingrown toenails, that is their business, not ours.

It just seems to me that we are getting a little out of our field when a taxwriting committee is asked to exclude, or include the healing arts professions.

Would you care to comment on that?

Dr. ROTH. You may have an answer that is responsive to your problems. From our point of view, we cannot subscribe to the philosophy that chiropractic services are a positive contribution to the health of the public.

Mr. BETTS. May I interrupt you right there?

I am not questioning that. You certainly have that right.

What I am saying is that it is not for this committee to make the decision. It is for the States, under our historic concept that the States have that responsibility. It is not for this committee to decide.

If the chiropractors come up here, I would tell them the same thing, that I don't think it is for us to say that they can.

It is for us to accept what the States have done. If the States say they can, that is their business. If they say they cannot, that is their business.

Dr. ROTH. I don't contest your statement, sir, about your responsibilities. I think as laymen the wise course is to get the best technical advice you can, and I believe that this has come from a multiplicity of highly authentic sources, including the HEW report, our own testimonies, and a great deal of literature. I think you have to decide how much attention to pay to these because chiropractic does have physical limitations.

Mr. BETTS. I am sure it does, but again, that is what we got into when we accepted medicare. That does not enter into whether or not it is right or wrong to accept chiropractors, or exclude them, or toe doctors, or Christian Scientists.

I mean that is a suggestion I have, and I appreciate your comments. Again, I am not taking sides, just for the sake of argument. You might have a statement there from some senior citizens' group saying they are against chiropractors. I get a lot of letters from people who say that they are over 65, and they think they should have the right to chiropractic treatment.

I am simply extending a little further the complications that Mr. Conable suggested, and I don't think you have solved them at all by asking us still to make the decision. We are still in a bind, because the States have licensed them.

Dr. ROTH. I agree with you, Mr. Betts, and I think these people are among those who need proper or better education.

In this country, you know, pursuit of nonscientific substitutes for medical care is not limited to what comes under the heading of chiropractic. There are many other peculiar survivals from other cultures, the coupling of the Orientals and herb doctoring and faith healing and all sorts of things that I think would be a mistake to try to underwrite in providing Federal subsidies for true health care.

It is what is good for the public that should be paramount, not what is good for any practitioner of any cult.

Mr. BETTS. Of course, you have to qualify that by saying that all of these cults you are talking about, without including chiropractors as cults, or Christian Science as a cult, are all restricted in their practice, are they not? Don't the States all restrict them? They are not allowed to operate and give drugs. There is only a certain restricted area in which they can operate.

I am not saying that they should be allowed to perform these services, but I am throwing out for consideration that if the States recognize them, that possibly what we should do is permit them to practice to the extent that the States license them.

I mean that is just a thought. Maybe I am the only one that has it, but it seems to me that it is certainly worthy of consideration.

Dr. ROTH. Well, I think I can better understand your concept of your dilemma. I hope, however, that you do not expect us to relent any in our opposition to the extension of such services.

Mr. BETTS. I think your opposition should be directed to the States, where the licensing authority is granted, and not to a tax-writing committee, to try and pass on who can and who cannot practice the healing arts.

Dr. ROTH. I assure you, we are intensely involved in the States where this is a problem.

Mr. HARRISON. May I add, Mr. Betts, that the medicare program as it is drawn and enacted, implemented, does provide services and indicates the kinds of services that may be included for payment or reimbursement, and then, the kind of services that cannot be included. To that extent, we already have on the books a law which has been acted upon by this committee in identifying services.

And the real question, then, is whether to expand that particular law to include another kind of service, which we classify in the cult area, or to delete from another portion of the same act, which relates to title XIX, the opportunity to provide those services where it is more broadly stated as to the nature of services to be included.

Mr. BETTS. I understand all that, and I question whether it was wise, and, going a little further, if we would do what you insist on, which is probably beyond the realm of possibility, but for the sake of an exaggerated example, the time could come when a committee here could suggest that M.D.'s be not allowed to practice.

If you are going to leave it up to us to make a decision, 25 years from now people may get worked up about the prices that Mr. Burke mentioned, whether it is right or wrong, and come here and say, "We are not going to let doctors practice under medicare."

Mr. HARRISON. You made that decision originally, when you adopted the medicare law.

Mr. BETTS. Of course you have the right to undo anything you have done. I bring that out as an exaggerated example of what could happen.

If we get to the point where we could decide who can and who cannot, we might envision the day there may be a committee which would say that doctors should be restricted.

Dr. ROTH. I understand there are some who say some day we may be replaced by computers, and maybe that is what you are talking about.

Mr. BETTS. I just throw that out as an example of the problem we have.

I want to commend you for your statement here, which I think has been very helpful.

I don't want you to take away the thought that I have anything against doctors, because I have not.

Dr. ROTH. Thank you, Mr. Betts.

Mr. BURKE. What proportion of the average family's health expenses would be paid by the minimum family policy under your proposal?

Dr. ROTH. I have no figure with which to answer this and place any reliance upon it.

I think that it should cover the overwhelming bulk of any average family's expenses, since these are largely hospital and doctor expenses. We would not go into the coverage of drugs, except if they took supplementary coverage. The supplementary coverages could carry it up to, I would think, almost 100 percent.

Many of the uncovered areas of course relate to nonpersonal health expenditures, research, education, training, and so on, but these are not the family expenses that you refer to.

I would think it would be upward of 80 percent, and as a ball park guess, if you took the supplements, that we refer to, it should be well over 90 percent.

Mr. BURKE. Your proposal exempts those over 65. Why would they be exempted from the coverage of your bill?

Dr. ROTH. Because they have substantially adequate coverage under title XVIII. And one other group we exempt for the same reason, those who are eligible for military care, because they essentially have all the coverage that we could provide.

Mr. BURKE. With relation to those people that you exempt from the provisions of the bill, who are taken care of under welfare, would this not increase the cost to many of the States on their health care programs?

Dr. ROTH. No; no one is exempted unless they are covered either through medicare or military medical services, so that I think this would not be true, if I understand your question.

Mr. BURKE. I am referring to those people who are taken care of under welfare.

Dr. ROTH. They are covered under our bill.

You see, we have really made no exclusions, as some other programs have, and perhaps these need to be considered, but we have not talked about the exclusions applying to aliens and various other categories of people that are even excluded under medicare, or that Mr. Reuther excludes under the guidelines for his program, as we have seen them to date.

We are really cutting in everyone who is not covered under some other adequate program.

Mr. BURKE. I would like to ask unanimous consent to include the explanation of chart 13, on pages 26 and 27 of the staff data relating to medicaid and medicare study, entitled "Physicians' Fees Have Increased More Rapidly Than the Estimates Assumed."

Without objection, the chart and the explanation of the chart will be included at this point in the record.

(The documents referred to follow:)

EXPLANATION OF CHART 13

Increases in Physician Fees

Between 1956 and 1965, physician fees had risen an average of 3 percent annually. The 1965 actuarial estimates assumed a continuation of this rate of increase.

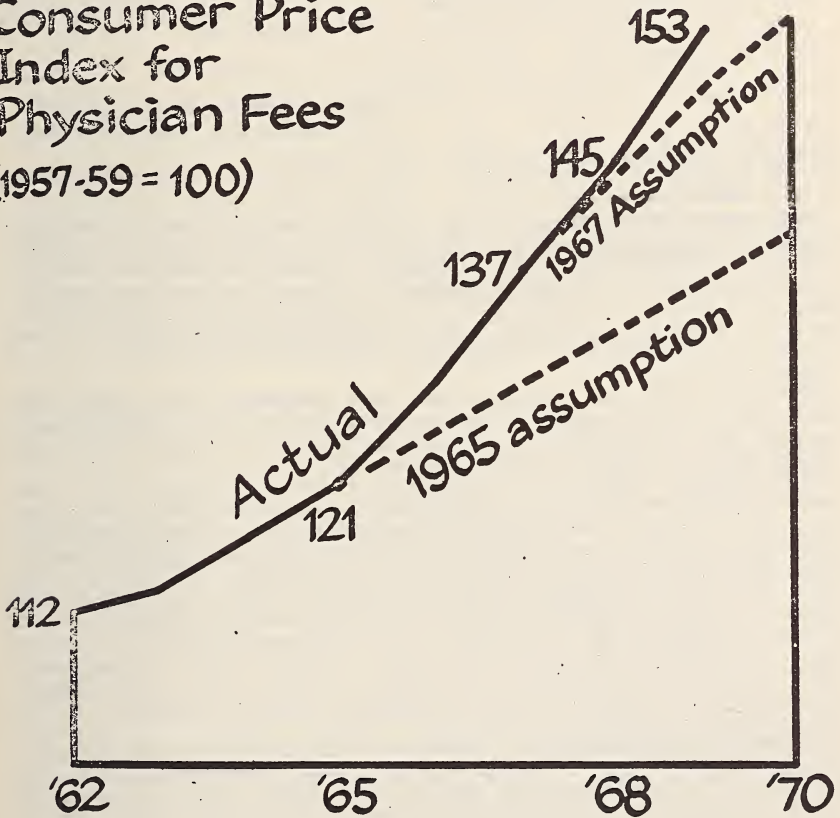
However, physician fees between June 1965 and June 1967 actually rose at an annual rate of 6.5 percent per year (compared to the 3-percent average rate of the previous 10 years). In setting the supplementary medical insurance premium which was to go into effect in April 1968, it was assumed that physician fees would rise at the rate of 5 percent per year between July 1967 and July 1969, and by 3 percent per year thereafter.

Between June 1967 and June 1968, physician fees rose 5.5 percent (compared with the 5-percent increase previously estimated). The late 1968 actuarial estimate assumed that physician fees would increase 5 percent in 1969, 4.5 percent in 1970, and 3.5 percent in 1971. Despite the actuarial estimates which indicated the need for a 10-percent increase in the monthly premiums, it was decided not to increase the \$4 monthly supplementary medical insurance premium on the assumption that either (1) there would be no increase in either physician fees or utilization of services between July 1969 and June 1970, or (2) reimbursement would much more often than in the past be based on less than the full charge. Between December 1968, the month of the promulgation of the \$4 premium rate, and April 1969 physician fees rose 2.8 percent.

CHART 13

Physician Fees Have Increased More Rapidly Than The Estimates Assumed

Consumer Price
Index for
Physician Fees
(1957-59 = 100)



Mr. BURKE. I wish to thank you, Dr. Roth. I believe you are the finest witness representing the AMA that I have had the privilege of listening to. You have shown a great sense of humor, which is unusual for the AMA.

I also wish to thank Mr. Harrison for his statements.

Let us hope that you keep on that road of trying to liberalize, because in my opinion I think you have a long way to travel to catch up with the 20th century, but good luck to you.

Mr. HARRISON. Mr. Chairman, I wonder, since we have not seen that publication before, or at least I have not, whether we might have an opportunity to comment on it at the same place in the record.

Mr. BURKE. The record will be left open at this point, without objection.

Mr. HARRISON. Thank you very much.

Mr. BURKE. You may have this copy if you like.

Dr. ROTH. Thank you, gentlemen.

(The following letter was received by the committee:)

AMERICAN MEDICAL ASSOCIATION,
Chicago, Ill., December 5, 1969.

HON. WILBUR D. MILLS,
Chairman, Committee on Ways and Means, U.S. House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN MILLS: At the time the American Medical Association appeared before the Committee on Ways and Means on November 3, Congressman Burke referred to chart 13 in a document which was prepared by the staff of the Senate Finance Committee relating to a study of medicaid and medicare. Chart 13, entitled, "Physician Fees Have Increased More Rapidly Than The Estimates Assumed," was included in the transcript of your Committee's hearings at page 1797. We were accorded an opportunity to present comments with respect to the chart.

The chart shows that physicians' fees have increased beyond program estimates. The document contains several charts, and it is to be noted that the increases are not limited to physician fees. Clearly, costs have also exceeded original estimates in other areas of health services.

The statement on page 26, accompanying and explaining chart A, is manifestly confusing, since it states that despite estimates indicating a need for a ten percent increase in the supplemental medical insurance premium no increase was requested on the assumption that either (1) there would be no increase in either physician fees or in utilization of services between July 1969 and June 1970, or (2) reimbursement would much more often than in the past be based on less than the full charge. It then states without further explanation, that between December 1968, the month of the promulgation of the \$4 premium rate, and April 1969, physicians' fees rose 2.8 percent. There is no explanation for the soundness of the stated assumptions, and this is the more puzzling in the face of the express statement that actuarial estimates indicated the need for the premium increase.

We are well aware, as is your Committee, of the increase in costs of medical care, including physician fees, and the need to keep these costs in proper perspective with all elements in our cost of living. While chart 13 shows an increase in the CPI for physician fees, it should be kept in mind that there are certain limitations of the Consumer Price Index. A serious shortcoming is its inability to fully consider quality changes, since it is extremely difficult to measure quality increase within the fee increase. In addition, of course, the general inflationary spiral has affected the physician as it affects all others. Increased rental costs and other operations expenses, including higher employee wages, higher costs of supplies and equipment, and malpractice insurance premiums, all have their part in the fee increases. The relationship of increased health costs to increased costs in other areas of our economy for the recent period of September 1968 to September 1969, was placed in the record by Congressman Fulton. Those statistics show the following: The cost of living has gone up 5.8 percent; food costs, 5.9 percent; housing, 6.8 percent; clothing,

5.3 percent; transportation, 3.4 percent; health and recreation combined, 5.6 percent; and services, 7.4 percent.

The American Medical Association is deeply concerned with the rising costs of medical care. One of our most pressing needs is the development of additional physician manpower to relieve the critical physician shortages—which shortages strongly influence the cost of medical care. To this end the American Medical Association again appeared before the Senate Appropriations Committee on December 2, 1969, to request maximum funding of programs supporting physician manpower training.

Thank you for this opportunity to comment on this portion of the testimony, and we request that this letter be inserted in the record at the appropriate place (page 1798 of the stenographic transcript).

Sincerely yours,

BERNARD P. HARRISON.

Mr. BURKE. Our next witnesses are the panel for the chiropractic association, Dr. Brassard, Dr. Day, Mr. Charles Youngs, Mr. Barnhart, and Mr. Rosenfield.

Dr. Brassard, we welcome you to the committee. I assume that you will want to present each witness.

PANEL OF CHIROPRACTIC ASSOCIATIONS: STATEMENTS OF DR. GERALD M. BRASSARD, PRESIDENT, AMERICAN CHIROPRACTIC ASSOCIATION; DR. WILLIAM S. DAY, FIRST VICE PRESIDENT AND CHAIRMAN, LEGISLATIVE COMMITTEE, INTERNATIONAL CHIROPRACTORS ASSOCIATION; CHARLES L. YOUNGS, UAW RETIRED WORKERS COUNCIL; E. PAUL BARNHART, CONSULTING ACTUARY; AND HARRY N. ROSENFELD, WASHINGTON COUNSEL, AMERICAN CHIROPRACTIC ASSOCIATION

STATEMENT OF DR. GERALD M. BRASSARD

Dr. BRASSARD. Thank you, Mr. Chairman.

Distinguished members of the Ways and Means Committee, I am Gerald M. Brassard, a practicing doctor of chiropractic from Beaumont, Tex. As president of the American Chiropractic Association, I am delighted to participate in a unified presentation on behalf of the entire chiropractic profession of the United States.

Mr. Chairman, if I may, I would like to introduce some of the members of the panel: Dr. William S. Day, of Spokane, Wash., chairman of the Legislative Committee of the International Chiropractors Association and a State senator from the State of Washington. Dr. Day is on my left.

Mr. Charles L. Youngs of Royal Oak, Mich., executive vice chairman of UAW's Wayne Area Retired Worker Council.

Mr. E. Paul Barnhart, St. Louis, Mo., consulting actuary, and Mr. Harry N. Rosenfield, attorney, Washington, D.C., Washington counsel for the American Chiropractic Association.

SUMMARY

Recommendation: Enactment of one of 62 House bills which would include chiropractic in medicare, Part B.

1. *Chiropractic is a recognized health profession.*

2. *Chiropractic services are of special importance to ever-growing proportion of medicare-age Americans. One-third of all activity-limiting conditions affecting persons 65 years or over is in area which doctors of chiropractic are best equipped to treat.*

3. *Chiropractic has been officially recognized by Congress* in medicaid, and for Federal civil service, income tax and immigration purposes, as well as for licensing of doctors of chiropractic in Washington, D.C.

4. *Chiropractic is officially recognized by the States:*

- (a) 48 States license Doctors of Chiropractic.
- (b) 19 States require commercial insurance to cover chiropractic.
- (c) 17 States include chiropractic in medicaid.

5. *Major veterans groups have passed resolutions asking Congress to include chiropractic in medicare.*

6. *Organized labor strongly supports chiropractic, by*

- (a) resolutions demanding chiropractic in medicare ; and
- (b) including chiropractic in its own health plans ; and
- (c) operating its own chiropractic clinics.

7. *Chiropractic education provides more hours of instruction in 6 basic subjects than medical schools.*

8. *All major health fields have similar lack of uniformity in State statutory requirements, a circumstance that is not relevant to medical coverage.*

We appear before you to urge the inclusion of chiropractic services in medicare, part B, to the extent that such services are authorized by State law, just as you have long included chiropractic in the medicaid program. Some 62 bills have already been introduced in the House to this end, two of them by distinguished members of this committee.

CHIROPRACTIC

Chiropractic is a study of health and disease from a structural point of view with special consideration given to spinal mechanisms and neurological relationships. Chiropractic is the largest drugless healing profession. It does not include the practice of surgery.

Doctors of chiropractic have been classified by the United States Public Health Service, in a 1966 study, as among "medical specialists and practitioners," including pediatricians, obstetricians, and ophthalmologists, among others. The PHS's Health Manpower Source Book includes doctors of chiropractic along with physicians, surgeons, and dentists.

HEALTH NEEDS

The National Health Survey conducted some 8 to 10 years ago, showed that of all the people in the United States with permanent impairments, 19 percent suffered from chronic impairment of the back or spine. ("Selected Impairments by Etiology and Activity Limitations," July 1959-June 1969, National Health Survey, series B, No. 35, page 22 (July 1962).) At today's population figures, this amounts to some 5,400,000 people.

In addition, the National Safety Council reports that "about 400,000 workers suffer disabling back injuries each year, and the number seems to be increasing faster than injuries in general. . . ." (National Safety Council, "Accident Facts," (1967 edition), p. 31.)

Chiropractic services are of special importance to senior citizens. According to the National Center for Health Statistics, almost twice as many people in the premedicare age (45-64 years of age) receive chiropractic services as does the population as a whole. (National Center for Health Statistics, series 10, No. 28, p. 37.) And this use of chiropractic by elderly patients has been increasing to an even higher percentage. (Higley, H. G., "Patients Past 65 Under Medi-Cal" (1968, unpublished).)

Another PHS report shows that one-third of all conditions causing activity limitations to persons 65 years of age and older were due to musculo-skeletal impairment. (National Center for Health Statistics, series 10, No. 32, p. 55.)

Among the general practitioners of the healing arts, doctors of chiropractic are better qualified by education and experience in the detection and correction of neuro-musculo-skeletal conditions and their effects, and in the referral of such patients where nonchiropractic methods of care would be more effective or necessary.

OFFICIAL STATUS

Federal: The Congress and the Government of the United States have officially recognized chiropractic as follows:

1. Medicaid authorizes chiropractic services under title XIX.
2. Federal civil service accepts chiropractic statements for sick leave of Federal employees.
3. Income tax permits medical deductions for chiropractic health care.
4. Immigration recognizes chiropractic colleges as a basis for student status of aliens.
5. Veterans' Administration recognizes chiropractic education.
6. The District of Columbia, by Act of Congress, licenses doctors of chiropractic.

STATE

Chiropractic has been officially recognized as a health profession in 48 States. Each State has specific laws defining the practice of chiropractic, prescribing requirements for licensure, and authorizing chiropractic services and care.

In addition, claims for chiropractic care are paid by: (1) workmen's compensation, in 48 States, and (2) medicaid, in 17 States.

INSURANCE PAYMENTS

Many hundreds of commercial insurance companies, including most of the private carriers which administer medicare, include chiropractic in their health and accident policies.

Eighteen States already have enacted "insurance equality laws" which, generally speaking, require the reimbursement of licensed doctors of chiropractic whenever the insurance policy provides for a health service which may legally be provided by a doctor of chiropractic in that State. These States are: California, Connecticut, Delaware, Illinois, Indiana, Maryland, Massachusetts, Michigan, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, Ohio, Rhode Island, Utah, and Virginia. This legislation involves 75 million Americans with health and accident policies issued by private insurance companies. In addition, we understand that some four States have such equality laws applicable to Blue Shield. The States are: Connecticut, Indiana, Massachusetts, and Nebraska.

I should also add that beginning last month, Blue Cross is paying for chiropractic services in Ontario, Canada.

DEMAND FOR CHIROPRACTIC SERVICES

Another witness will describe the grassroots demand by senior citizens for chiropractic services in medicare. I should like very briefly to outline some of the grassroots demands by organized labor and by veterans' groups for chiropractic coverage in medicare.

I. ORGANIZED LABOR

A substantial number of State labor federations, municipal central labor bodies, and regional, district, and local unions embracing more than 6½ million trade unionists have gone on record in the past 2 years for chiropractic inclusion in medicare.

Significantly, these include some of the largest State AFL-CIO affiliates, such as New York, Pennsylvania, Illinois, New Jersey, and Texas. In addition, similar actions have been taken in Arkansas, Florida, Georgia, Oregon, and Washington State.

As an example of these State federation resolutions, may I quote from resolution No. 36, adopted by the Seventh Biennial Convention of the Arkansas State AFL-CIO, in May 1969:

That we believe that title 18 of the Social Security Act should be amended to provide for chiropractic services.

This resolution, which is generally similar to others adopted by these State federations, also states that:

* * * chiropractic services, as authorized by Arkansas law and this State's workmen's compensation program, have proved to be highly beneficial to workers and their families in this State.

In addition, many local unions have adopted resolutions demanding chiropractic services in medicare. Recently, two of the largest districts of the steelworkers did so, as have unions of transit workers; Federal employees; State, county, and municipal employees; painters; milk drivers; longshoremen; retail clerks; and organizations of policemen and firemen.

At least four UAW locals insisted on chiropractic's services because the white-collar employees of GM and Chrysler already have access to such services. And it is significant, we believe, that the mayor of a union town such as Dearborn declared the week of August 25-29, 1969, as "Chiropractic Services Week," and urged chiropractic inclusion in medicare.

But even more than resolutions is the actual operations of union health and welfare funds. Some of the more outstanding of these programs have been deliberately negotiated by trade unions precisely to include chiropractic. For example, the State, County, and Municipal Workers, and dozens of other unions that have contracts with the city of New York, with more than 230,000 members covered, have included chiropractic in their health insurance plan.

The State of California has more than 100 separate union health and welfare programs with chiropractic coverage, ranging from such diverse industries as the motion picture community to meat cutters and longshoremen.

The same situation prevails in New York. And virtually every large affiliate of the AFL-CIO, the Teamsters, United Auto Workers, and major independent unions have some recognition and inclusion of

chiropractic, ranging from international union industrywide contracts to those negotiated on a regional, district, statewide, or local union level.

Other unions, such as the Candy and Confectionary Workers Union and the Uniformed Sanitationmen's Union of New York City, have established their own chiropractic clinics as part of permanent health care centers for the use of their members. In operation for more than 2 years, both clinics report satisfactory experience.

II. VETERANS' GROUPS

1. The Veterans of Foreign Wars, at their 70th National Convention in August 1969, adopted resolution No. 155, which states, in part:

* * * that we go on record as urging the Congress of the United States to amend the Social Security Act to cover our elder citizens and veterans needing chiropractic treatment for their various ailments.

2. AMVETS, at their national convention in August 1967, adopted resolution No. 160, which states, in part:

* * * do urge all Members of Congress and the President of the United States to make chiropractic care and the services of chiropractic physicians available to all recipients of service under medicare and medicaid * * *.

3. The American Legion, department of Texas, at its annual convention in August 1969, adopted a resolution asking inclusion of chiropractic in medicare. Similar views have been expressed by resolutions adopted in local posts in Texas and Arkansas, among other States.

4. The Veterans of World War I, in New York and Texas department, passed resolutions for chiropractic coverage by medicare.

These are only selected examples of veterans' demands for chiropractic services in medicare.

CHIROPRACTIC EDUCATION

Chiropractic colleges require a minimum of 4 academic years of resident professional study, including clinical experience under strict supervision.

Chiropractic colleges provide more hours of instruction than medical schools in the following six basic subjects:

1. Anatomy.
2. Physiology.
3. Radiology.
4. Rehabilitation.
5. Nutrition.
6. Public health.

In this connection, I submit for the committee's record a copy of "Chiropractic's White Paper," which documents these educational data, and also provides the facts to deal with questions of diagnosis by doctors of chiropractic and the effectiveness of chiropractic services.

STATUTORY REQUIREMENTS

In closing, I should like to refer to a claim that is sometimes heard, alleging a lack of uniformity in the statutory requirements by the various States on chiropractic.

First, let me say that this situation has been blown out of all proportion. It is not truly relevant to the medicare program.

Second, you should know that the same situation prevails in other major healing arts which are already included in medicare.

For the record, I submit a study of 15 States, with a synopsis of selected requirements for licensure in medicine, osteopathy, dentistry, optometry, and podiatry, showing lack of uniformity in licensure and educational requirements.

Again, I respectfully suggest that such lack of uniformity is no more relevant to chiropractic in medicare than it is in the other allied healing professions.

In conclusion, may I express our thanks for the opportunity to testify. We urge you to include chiropractic services in the medicare program, as proposed by the numerous bills now before the committee.

If I may, Mr. Chairman, our next witness is Dr. Day, from Spokane, Wash.

Mr. BURKE. Dr. Day, you may proceed.

**STATEMENT OF DR. WILLIAM S. DAY, FIRST VICE PRESIDENT
AND CHAIRMAN, LEGISLATIVE COMMITTEE, INTERNATIONAL
CHIROPRACTORS ASSOCIATION**

Dr. DAY. Thank you, Dr. Brassard.

My name is Dr. William S. Day, and I am a practicing chiropractor in Spokane, Wash. I testify as first vice president and chairman of the legislative committee of the International Chiropractors Association.

I am also a member of the Senate of the Washington State Legislature, and chairman of its Committee on Medicine, Dentistry, Drugs, Air and Water Pollution, and also serve as chairman of the Legislative Council's Committee on Public Health and Welfare.

SUMMARY

Recommendation: Chiropractic should be included in medicare, Part B.

1. *Prohibition Against Federal Interference* assured by § 1801 requires inclusion of chiropractic in Part B.

2. *Freedom of Choice*, guaranteed by § 1802, means the patient's Freedom of Choice to obtain the services of State-licensed chiropractors.

3. *State Workmen's Compensation Programs* prove that chiropractic care gets injured employees back on job quicker, thus saving wages and productivity and assuring higher state tax revenues and less state costs.

Mr. Chairman, this is the first time that both the American Chiropractic Association and the International Chiropractors Association have appeared jointly before a legislative committee in a joint and unified presentation. I join Dr. Brassard in urging you to amend title XVIII of the Social Security Act to include chiropractic services in medicare, part B.

As a State legislator, and speaking for what I know to be the reaction of virtually all State governments, I believe that such an arrangement is wise, and that it conserves and preserves the time-tested genius of this Nation's Federal-State system.

PROHIBITION AGAINST FEDERAL INTERFERENCE

In enacting medicare, the Congress sought to protect our system of federalism. The very first section of title XVIII is entitled, "Prohibition Against Any Federal Interference," section 1801. And yet, this guarantee is vitiated through interference with States' freedom effectively to make available to their elderly citizens the health services of chiropractors.

As has already been stated, 48 States, Puerto Rico, and the District of Columbia recognize and license the practice of chiropractic. Therefore, the Federal medicare law, by denying coverage of chiropractic services, penalizes the citizens of the States and interferes with the operation of such State laws within the respective State boundaries.

Such Federal interference with the States under medicare, title XVIII, is all the more unjustifiable because of the noninterference—and the consequence allowance of coverage of chiropractic services—under medicaid, title XIX. Thus, of the States which have adopted medicaid legislation, some 17 already authorize chiropractic services.

Therefore, we have the following strange results under the present law:

1. The medically indigent, as the Congressman stated earlier, can obtain chiropractic services under medicaid, title XIX.

2. But the medically self-sufficient, who voluntarily pay premiums, cannot obtain chiropractic services under medicare, title XVIII.

I respectfully suggest that this is an unwarranted Federal intrusion upon the States, that it is bad law, and that it prohibits medicare beneficiaries from obtaining needed chiropractic health care.

FREEDOM OF CHOICE

This brings me to my second point, that the present law flies in the face of section 1802 of the Social Security Act, "Free Choice by Patient Guaranteed." The law guarantees the patient's freedom of choice to obtain health services from any qualified institution, agency, or person.

Despite this assurance, America's self-supporting elderly are denied effective freedom of choice to obtain the needed and beneficial health services of State-licensed chiropractors. When such freedom of choice is denied, medicare not only denies older people the health protection they want and need, but it also affronts the independence and dignity which medicare is designed to assure.

This fact involves not only fundamental theories of the relation between the Federal and the State governments, and the relation between the American citizen and his Government, but also the individual health, comfort, and well being of each and every senior citizen.

Gentlemen, as a State legislator, I urge you to rectify this improper exclusion. Forty-eight States license doctors of chiropractic because their legislatures and Governors believe that chiropractic helps their people to maintain and regain their health.

Many people around this broad land are beginning to wonder whether the Federal Government is trying in effect to "take over" from the States the licensing of doctors, dentists, chiropractors, and other health services. I am sure that the Congress will not permit this, but

I am equally sure that one of the best ways for the Congress to preserve federalism within medicare is to permit the people in the various States to use chiropractors to the extent and for the purposes permitted by State law. Anything else is a breach of fundamental Federal-State relations, and a de facto Federal "take-over" of the licensing of allied health professions.

VALUE OF CHIROPRACTIC SERVICES

Third, as a State legislator, I am, of course, sensitive to the activities of State agencies in my own State and elsewhere in the Nation. One of the most unbiased and reliable criteria of the effectiveness of chiropractic services is to be found in the operations of State workmen's compensation programs, which include chiropractic benefits. This experience seems to prove three things about chiropractic:

1. Injured workers who use chiropractic care get well quicker and lose less wages because of illness of the same kind and severity for which others turn to medical treatment.

2. Employers find that chiropractic care brings their injured workers back to the job more rapidly. Thus, industry suffers less loss of productivity and earns lower compensation rates.

3. The States profit from chiropractic care in compensation cases, through lower State costs, increased tax revenues through increased productivity, and lesser calls upon State funds to supplement the reduced income of injured workers' families.

Thus, everyone wins when chiropractors are permitted to serve the needs of people who want their services. That is why the States license them and pay for their services in workmen's compensation.

That is why I urgently recommend to you that this committee should favorably report out a bill which includes chiropractic in medicare.

Thank you, gentlemen.

Our next witness is Mr. Charles Youngs, executive vice chairman, United Auto Workers Retired Workers Council.

STATEMENT OF CHARLES L. YOUNGS, UAW RETIRED WORKERS COUNCIL

Mr. YOUNGS. Thank you, Dr. Day.

I am Charles L. Youngs, Royal Oak, Mich., native-born citizen, and World War I veteran. I have been retired for 31½ years from the Chrysler Corp.'s engineering division automotive body design group.

Despite my present age of just under 72 years, I still am in demand by Detroit area job shops contracting engineering and design projects from Chrysler, Ford, General Motors, et cetera, have worked for Creative Industries of Detroit—11½ years—and am now employed by the Martech Corp., Ferndale, Mich., where, during the past year, I have worked up to a 56-hour workweek.

Admittedly, I am one of those fortunate few to whom this opportunity comes, and both my employers have honored and accepted my multitudinous retiree organizational activities and consequent time off the job.

Since my retirement, I have assisted in organizing within the international union, UAW, its present three-level retired member organi-

zation, which is dedicated to beneficial action in the field of community affairs and service, not only for its own retired workers and their families, but for those of the Nation and all citizens generally.

In that organization, I am president of my own local union's 700-member Retired Worker Chapter. I am also chairman of the UAW's 60-delegate region 1 Retired Worker Council, representing some 17,000 UAW retirees in region 1 alone, and executive vice chairman of the UAW's 180-delegate Wayne Area Retired Worker Council which, in the community affairs and service field, represents more than 70,000 UAW retirees in its regions 1, 1A, 1B, and 1E of southeastern Michigan. A substantial portion of these retirees are familiar with, and enthusiastic beneficiaries of, chiropractic services.

I am also a member of our statewide UAW Retired Member Legislative Committee, which is a major voice and force in behalf of beneficial legislation for senior citizens throughout Michigan.

In these capacities, I am in frequent contact with many senior citizen activities and groups and somewhat conversant with their problems, hopes, and aspirations, one of which is the lack of availability of chiropractic under medicare.

Hence, I gratefully and eagerly accepted the gracious invitation of the chiropractic profession to come to Washington and upon their time before this committee to urge upon you honorable members the prompt inclusion of the healing art and practice of chiropractic under the provisions of the medicare portion of the Social Security Act.

I come at my own expense, and in my own words enter this heartfelt plea that millions of our Nation's faceless, voiceless senior citizens now under medicare receive those benefits of chiropractic they so badly need, and on the same financial basis as they now receive their appreciably higher priced medical services.

As a firm believer in and recipient of those benefits which only chiropractic provides, I am doubly appreciative of your courtesy.

My own experience is so characteristic of many retirees that it helps to explain their insistence upon chiropractic benefits in medicare.

For some 45 years past, chiropractic has been a major reliance of mine, and, for my wife and her family, some 15 years before that. For 42 of those 45 years, I have been entirely free of recourse to medical services.

Almost invariably, chiropractic services are first received as a result of desperation moves to obtain relief from ailments either not recognized by, or beyond the training of, the medical doctors involved.

My own experience started in 1924, with just such a desperation move, relief for an ailment resulting, as I eventually learned, from a semi-pro baseball playing incident of some 9 years before. By 1924, the ailment had become chronic. It did not respond to medical treatment, but it responded promptly and unbelievably well to chiropractic treatment. Five chiropractic adjustments not only freed me of the ailment at the time, but also against its return for some 8 years thereafter. Infrequent adjustments since then have kept me free of the earlier condition, and, since proper chiropractic treatments involve all necessary adjustments to the entire spinal column, have kept me in surprisingly good health since.

Chiropractic, for me, thus becomes, rather than a timely cure of a particular ailment, a general health safeguard, instead. Periodic

recourse to chiropractic helps greatly to build as well as preserve good health.

During most of the past 40 years, I have carried group insurance coverage against the possible excessive costs of sickness, accident, hospitalization, surgery, and/or medical assistance. In all those years, fortunately, I needed and have received only 1 week's compensation under such coverage.

I have carried medicare B, and paid its premiums, from its very inception, as my wife also does. Incidentally, just 6 weeks ago, we celebrated our 48th anniversary. Yet, neither of us can recover a single penny of any costs of necessary chiropractic services. And that is the dilemma of millions of our fellow senior citizens across the Nation.

A medical doctor can receive from medicare 80 percent of an \$8 to \$12 office call fee for a cursory examination of a medicare patient—and many of them do just that—yet, the senior citizen needing chiropractic treatment must meet the full cost out of his usually tragically small income—at the very time of life such relief is most critically needed. His only break comes from the usually appreciably smaller fee of \$4 to \$6.

Senior citizens all over the Nation are becoming alerted to the inequities of their present health program under medicare—and increasingly restive under its restrictions. Hopefully, they will not have to gird for battle to obtain needed benefits now, while they still live, rather than later for their successors.

In evidence of this growing sentiment and alarm, I call your attention to the fact that resolutions have been passed by statewide senior citizens organizations in Arkansas, Florida, Oregon, Texas, and Wisconsin, and many other local organizations in other States, calling upon the Congress promptly to correct these existing inequities by including in medicare chiropractic health protection and financial assistance, which their proponents have long since earned.

I strongly urge them upon your attention and consideration. Many, many more senior citizen groups have the same views, including our UAW retirees and special groups like the Polish-American Senior Citizen Council of Chicago.

Our Nation's elderly are just as much entitled to the health-preserving and protecting services of the chiropractic profession as to the present primarily drug-dispensing services of the medical profession, valuable as they admittedly are.

Thank you for your courtesy in hearing my earnest plea for the prompt inclusion of chiropractic under medicare, on an equal footing with the medical profession, which now so largely monopolizes, at the time their needs are greatest, the health service field among our Nation's senior citizens.

At the time the needs are greatest, please give us chiropractic coverage under medicare.

Now, Mr. Chairman, our next witness is Mr. Paul Barnhart.

STATEMENT OF E. PAUL BARNHART, CONSULTING ACTUARY

Mr. BARNHART. Honorable Chairman and members of the committee, my name is E. Paul Barnhart, and I am a professional consulting actuary with offices in St. Louis, Mo. I am a health insurance specialist,

and I was retained by the American Chiropractic Association to conduct an independent actuarial study as to the probable cost of extending coverage under part B of medicare to include chiropractic services.

In preparing this study, I employed all relevant data that I could find which have a meaningful bearing on this subject. This included data published by the U.S. Public Health Service, data published by the Social Security Administration concerning the medicare program, data published relating to the California old age security program, data published by several of the State industrial commissions relating to chiropractic treatment of industrial injuries, and surveys conducted by the American Chiropractic Association.

The study is annotated to identify each of these sources and the information which I have drawn from them.

The final two pages of the study, pages 17 and 18, contain a summary of my conclusions, which briefly are as follows:

1. The maximum probable benefit's cost of extending part B of medicare to include chiropractic services, for the current year of 1969, would have been 11 cents per month per part B enrollee, if we consider part B alone. The Federal Government's share of this benefit cost would be half that amount, or 5.5 cents.

2. Certain savings, however, can be expected to result under part A of the medicare program as a result of extension of coverage to include chiropractic care, because there would be some reduction in hospital utilization among medicare claimants. I estimate that these savings would reduce the total cost about 5 percent, to 10.5 cents per month per enrollee, of which the Federal Government's share would be 4.98 cents.

These estimates are drastically different from those arrived at by the Actuarial Division of the Social Security Administration in developing its own cost estimate. The SSA estimate, comparable to my 11 cents, is 24 cents per month per enrollee, more than twice as high as my figure.

Because of this considerable discrepancy between the two estimates, I have attached to my study an appendix which contains an analytical critique of the assumptions used in the SSA cost estimate. I strongly challenge the accuracy of several of the major assumptions used. Some of them are obviously and demonstrably erroneous.

For example, the SSA estimate assumes that there are 23,000 chiropractors in private practice in the United States. Its source for this figure is U.S. Public Health Service Publication No. 1509, entitled "Health Resources Statistics, 1965."

This document indeed reports the estimated 23,000 chiropractors. However, the 1968 edition of this very same publication, "Health Resources Statistics, 1968," states, on page 49:

About 19,100 chiropractors were licensed at the end of 1965 in the United States, according to estimates based on a survey published in the American Chiropractic Association's Journal of Chiropractic (table 23). Of the 19,100 chiropractors, licensed in 1965 in the United States, perhaps 15,000 to 17,000 were actively engaged in practice at that time. This is substantially less than had been estimated in the earlier edition of this publication.

Since this 1968 edition was published in December of 1968, it was available to SSA at the time its cost estimate was prepared, in February 1969, and I do not understand why this latest available edition was not used.

Use of the 17,000 figure, the upper limit of the estimated number of practicing chiropractors as reported in this latest 1968 edition, instead of the 23,000 estimate actually used by SSA, reduces the higher of the two SSA results by 26 percent.

But this is only one of several erroneous or highly questionable assumptions employed by SSA. As my appendix shows, when the most major of these several assumptions are corrected to more reasonable and supportable figures, the SSA result comes very close to my own estimate. In fact, it turns out to be 12.3 cents, as compared to my "high cost" estimate of 13 cents, and my "most probable" estimate of 11 cents.

In view of such considerations as these, I think there is little question but that my 11-cent estimate is far more realistic than the 24-cent figure developed by SSA.

Even so, it would be desirable to confirm this conclusion through some additional outside source, since your committee now has before it two conflicting actuarial estimates. An independent source exists, and it may be found in the experience of commercial insurance carriers. In behalf of one of my commercial company clients, I recently had occasion to study this same question, that is, the cost of extending coverage to chiropractic services, and in connection with this study I interrogated 19 major health insurance writers as to their experience resulting from such extension of coverage.

All of these are large carriers, operating in most States, and all have had at least some experience in relation to recognition of chiropractic services, since in several States insurance laws enacted in the last few years have required that carriers recognize chiropractors for any covered services they are legally qualified to perform.

The 19 carriers combined, in 1967, wrote health insurance premiums totaling \$3,879,000,000, or 44 percent of all the commercial health insurance in the United States, so their combined experience represents a large fraction of the total health insurance experience of the country. Several of them are also participants in the administration of the medicare program.

Here is a summary of the responses of the 19 companies to my inquiry:

1. Fifteen out of the 19 companies are now voluntarily recognizing chiropractic services in all States, not only those where they are legally obliged to do so. The majority of these 15 have been following this practice for many years. The remaining four are recognizing chiropractors only in the several States where they are legally required to do so.

2. Nine of the 19 companies reported that they have detected no apparent change in total claim payout which they could attribute to the inclusion of chiropractic services. Two of the 19 were of the opinion that a slight increase in costs had resulted, although in neither case was this opinion a clearly established statistical fact; it was, rather, an impression based only on general observations. The remaining eight did not have an answer to the question of change in cost, for the most part because their practice of recognizing chiropractors dated back so far that no basis of comparison existed. All of the statistical data of these eight included coverage of chiropractors for those covered services they are legally qualified to perform.

3. Of the four carriers recognizing chiropractors only in those States where legally required, which requirement has in most such States been of rather recent enactment, three reported no apparent change in costs in those States. The fourth did not have an opinion, having not yet analyzed their experience to draw any conclusion on this score.

The general conclusion to be reached from this survey of commercial carriers is that no significant net change in costs resulted from their expansion of coverage to chiropractic services.

I submit this study, together with its appendix, for your committee's record of this hearing, and I strongly urge your committee to give careful consideration to the information presented in the study and appendix in your deliberations concerning possible revisions in the medicare program.

Mr. BURKE. Without objection, your appendix and the charts here will be included following your statement.

(The documents referred to follow:)

ACTUARIAL STUDY CONCERNING THE COST OF INCLUDING CHIROPRACTIC SERVICES IN FEDERAL "MEDICARE"

(Prepared by E. Paul Barnhart, F.S.A., Consulting Actuary, August, 1969¹)

INTRODUCTION

The object of this actuarial study is to determine, so far as available facts and statistics permit, what probable amount, if any, would be added to the cost of Federal "Medicare" as a direct result of expanding that program to include the cost of chiropractic services. The estimates of this study relate to cost levels and Medicare enrolled population as of the current year—1969.

Only a limited amount of statistical information is available which has a direct and immediate bearing on the subject. To some extent it has been necessary to make use of information which is only of indirect assistance in finding the answers, and to draw conclusions as to the probable effects through inference. Nevertheless, it has been possible to arrive at such conclusions with a considerable degree of confidence, and these are presented in the concluding section of this report.

I. THE COMPARATIVE COST OF CHIROPRACTIC SERVICES IN RELATION TO THE SERVICES OF OTHER PRACTITIONERS

There appear to be only scattered sources of information on this important question, and some of the extant data are now several years old. Consequently, in order to gather a body of recent data on this subject, the American Chiropractic Association, in cooperation with the Iowa State Industrial Commission, conducted a survey of Workmen's Compensation claims incurred during the calendar year 1966. This survey was conducted under the direction of Dr. Louis O. Gearhart, D.C. (at that time Director of Professional Affairs of the American Chiropractic Association) with the benefit of my actuarial advice.

In order to confine the survey to a reasonably homogeneous group of injury cases, it was limited to cases classified as "back injuries" only. During 1966, there were a total of 2518 such claims filed with the Iowa Workmen's Compensation Service. These cases were classified according to whether treatment was rendered by a Doctor of Chiropractic (D.C.), on the one hand, or by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), on the other. The results are as follows:

Total number of cases classified as back injuries—2518.

Total number of cases treated by D.C.—389 or 15.4%.

Total number of cases treated by M.D. or D.O.—2129 or 84.6%.

¹ This Study is a revision of an original study prepared in June, 1968, and updates all cost estimates to the year 1969.

Average number of cases treated per month by :

D.C.—32.4 cases ; M.D. or D.O.—177.4 cases.

Average work time loss per case under care of :

D.C.—2.64 weeks ; M.D. or D.O.—5.62 weeks.

Average cost per case for treatment under care of :

D.C.—\$68.24 ; M.D. or D.O.—\$118.74.

Average cost per case for hospital charges under care of :

D.C.*—\$20.23 ; M.D. or D.O.—\$121.98.

Average cost per case for other charges (braces, supports, etc.) :

D.C.—\$0.81 ; M.D. or D.O.—\$4.18.

The average cost per case, where treatment was under the care of a D.C., was only 57.5% of the average cost when care was rendered by an M.D. or a D.O. (\$68.24 vs. \$118.74).

There is, of course, an obvious potential flaw in this comparison. It is possible that the claimants more commonly sought the care of D.C.'s in cases of minor back sprains, whereas M.D.'s or D.O.'s were more commonly in attendance on cases of major injury involving surgery and hospitalization. From the Iowa records reviewed, it was not possible to subdivide further the category "back injuries" as to exact diagnosis and severity. It is known, however, that the great majority of such injuries are in fact sprains and strains, as may be readily verified from other sources. The following statistics are given in the study "Back Injuries: A Major Health Problem in the United States", compiled under the direction of Henry G. Higley:²

Lost time back injury claims filed in 1961 with the Industrial Commission of Ohio

Contusions, bruises.....	1, 806
Dislocations	3
Fractures	245
Lacerations	29
Sprains and strains.....	11, 505
All other.....	53
Total	13, 641
(Sprains and strains comprised 84.3% of the total)	

Compensation cases closed in 1963 by New York Workmen's Compensation Board

Herniated disc.....	1, 397
Fractures and dislocations.....	743
Strains and sprains.....	14, 899
All other.....	767
Total	17, 806
(Sprains and strains comprise 83.7% of the total)	

Comparable data shown for the State of Washington (fiscal year 1963-64) indicate that sprains and strains accounted for 92.1% of 5,189 back injury claims filed.

Accordingly, we may conclude with certainty that the great majority of cases treated by both categories (D.C., and M.D.-D.O.) of practitioners in the survey of 1966 Iowa claims were sprains and strains of the back, and the average cost of such treatment was significantly lower where rendered by a D.C.

Similar comparative figures are given in another study³ carried out several years ago for the Insurance Relations Committee of the Florida Chiropractic Association. This study, conducted in 1960, examined the records of claims filed in 1956 with the Florida Industrial Commission, and was specifically limited to

*There is no inference intended to indicate treatment in hospitals by the D.C. Rather, some time in the history of the case (whether treated by the D.C. or others) there were hospital charges involved before the case was reported as closed by the Workmen's Compensation Service.

² "Back Injuries: A Major Health Problem in the United States" prepared by the Department of Research and Statistics, American Chiropractic Association; Henry G. Higley, M.A., D.C., Chairman. (Copyright, 1966, American Chiropractic Association.)

³ "A Survey and Analysis of the Treatment of Sprain and Strain Injuries in Industrial Cases" prepared for the Insurance Relations Committee, Florida Chiropractic Association, April, 1960.

19,666 individual cases of sprains and strains of the neck, spinal vertebrae and external back. The results were:

	Average per case treated by—	
	Chiropractors	Medical doctors
Total cost of treatment.....	\$51	\$65
Work days lost.....	3	9
Number of treatments.....	9	6
Average cost per treatment.....	\$5. 67	\$10. 83

Average total cost of treatment, when rendered by a D.C., was 78.5% of the average total cost when treatment was rendered by an M.D. The average D.C. "per treatment" cost was only 52.3% of the M.D. average.

As mentioned above, the average total cost of treatment for D.C.'s in the Iowa survey was 57.5% of the average for M.D.'s and D.O.'s combined. This lower figure undoubtedly results in part from the inclusion of all forms of back injury cases in the Iowa survey. In the Florida survey, the cases studied were narrowly limited to sprains and strains of the neck, spinal vertebrae and external back. Accordingly, these cases were highly homogeneous in character, and since they were cases involving only sprains and strains, injuries involving major surgical correction and other complications were excluded. Accordingly, the Florida study compares the cost of chiropractic to other types of professional treatment with respect to narrowly homogeneous and similar injury cases. The cases in the Iowa study are less homogeneous, and, as one might well expect, the divergence in cost between chiropractic and other forms of treatment is greater (57.5% in the Iowa study, compared to 78.5% in the Florida study). Consequently, the Florida study must be regarded as a more reliable measure of the comparison under *equivalent* injury cases. This evidence would indicate that the average cost of total treatment, when rendered by D.C.'s, may reasonably be assumed to run between 70% and 80% of the average cost of treatment of comparable conditions by M.D.'s and D.O.'s.

It is quite important to recognize that the comparative cost of treatment must be determined, for our purposes here, on the basis of *average total cost of treatment*, not on some other basis such as average charge for an office visit or even average cost per treatment. If the comparison is made on the basis of average charge for an *office visit*, too high a ratio will result. If the comparison is made on the basis of average cost *per treatment*, too low a ratio will result.

The reason for the latter is that the average *number* of treatments, per case, is higher for chiropractic care than for other professional care (9 vs. 6, in the Florida study). The reason for the former is that, when care is given by an M.D. or a D.O., the amount of *other* charges, in addition to the simple charge for an *office visit*, will be greater. These will involve such items as injections or other doctor-administered drugs, diagnostic x-ray and laboratory examinations, and, in some instances, surgery.

A study⁴ made by Batten and Associates, in 1963, showed the usual charge by a chiropractor for a "routine office visit" to be \$4.34. A "Fee Guide" published in 1962 by *Medical Economics* showed the similar charges, by general practitioners and internists, to be \$4.25 and \$5.75, respectively. Thus, if a comparison were drawn purely from such comparative charges as these, one might be drawn erroneously to the conclusion that the average cost of chiropractic care runs about 85% as high as when such care is rendered by a mixture of general practitioners and internists. As shown above, however, a more valid cost comparison, based on *average total cost of treatment*, will fix the ratio between 70 and 80%.

II. GENERAL INCIDENCE AND AVERAGE COST OF CHIROPRACTIC CARE AMONG OLDER PERSONS

One source of data which deals specifically with chiropractic care of older persons is some information contained in a research report prepared by Henry G. Higley, entitled "Chiropractic in Public Assistance Medical Care in the State of California".⁵

⁴ "Chiropractic Survey and Statistical Study," Batten and Associates, Inc., 1963.

⁵ "Chiropractic in Public Assistance Medical Care in the State of California," a Review and Data Analysis by Henry G. Higley, D.C. (published in March, 1968, issue of *The Chirogram*, Journal of the Los Angeles College of Chiropractic.

This report shows the average cost of services per case under chiropractic care, under the California Old Age Security program, to be \$33.11, compared to an average for all professions combined of \$76.67. The period covered by the report was July, 1962 to June, 1964. The report also shows the percentage of those eligible who utilized chiropractic services, by six-month intervals within the 2 year period, as follows:

	Percent
July to December 1962-----	3.66
January to June 1963-----	3.88
July to December 1963-----	3.71
January to June 1964-----	3.72

These figures show a very stable rate of utilization of chiropractic services among persons eligible for Old Age Security Assistance. The total number of patients under chiropractic care during the 2 year period was 39,253.

In view of the deductible which applies to Part B of Medicare, it is of importance to have some knowledge of the distribution of chiropractic costs by size. To my knowledge, there is no data available on this matter which pertains specifically to persons above age 65. However, one study does exist⁶ which presents statistics on distribution of costs under group and individual health insurance claims for spinal injuries generally, i.e., without regard to age. This study includes a continuance table showing the distribution by size of 982 such claims incurred in Oregon over a 9 month period ending in May, 1966. The average claim was \$34.35:

Cost in dollars	Number of claims	Cost in dollars	Number of claims
\$1 to \$10-----	209	\$91 to \$100-----	21
\$11 to \$20-----	241	\$101 to \$110-----	12
\$21 to \$30-----	174	\$111 to \$120-----	7
\$31 to \$40-----	91	\$121 to \$150-----	11
\$41 to \$50-----	66	\$151 to \$200-----	2
\$51 to \$60-----	52	Over \$200-----	3
\$61 to \$70-----	42		
\$71 to \$80-----	33		
\$81 to \$90-----	18		
		Total-----	982

The same data, shown in more directly usable actuarial form, appears as follows, where Column 1, "Cumulative No. of Claims" means the number for which the cost equals or exceeds the dollar bracket, and is a reverse summation of the table above. Column 2 shows the corresponding amounts of dollars which fall in or above the bracket, and Column 3 shows the percentage of total charges which fell in or above the bracket:

Cost in dollars	Cumulative number of claims (1)	Cumulative dollars (2)	Cumulative percent (3)
\$1 to \$10-----	982	33,740	100.0
\$11 to \$20-----	773	24,129	71.5
\$21 to \$30-----	532	16,881	50.0
\$31 to \$40-----	358	11,909	35.3
\$41 to \$50-----	267	8,622	25.6
\$51 to \$60-----	201	6,249	18.5
\$61 to \$70-----	149	4,453	13.2
\$71 to \$80-----	107	3,152	9.3
\$81 to \$90-----	74	2,231	6.6
\$91 to \$100-----	56	1,581	4.7
\$101 to \$110-----	35	1,126	3.3
\$111 to \$120-----	23	836	2.5
\$121 to \$150-----	16	641	1.9
\$151 to \$200-----	5	326	1.0
Over \$200-----	3	135	.4

⁶ "Summary of Cost of Chiropractic Care of Industrial, Auto, and Other Injuries Involving the Spine in the State of Oregon," a Review and Data Analysis by Henry G. Higley, D.C. (published in February, 1968, issue of *The Chirogram*).

Since the average claim of \$34.35 comes very close to the figure of \$33.11 for California Old Age Security recipients, it appears reasonable to assume that the continuance patterns are fairly similar; in fact, the probability is that the Old Age Security pattern would be still more concentrated in the lower brackets. The cumulative percentage column above shows that only 18.5% of total charges would have exceeded a *per claim* deductible of \$50. Part B of Medicare provides for a *calendar year*, not a *per claim*, deductible, but this data will nevertheless provide useful guidance in estimating what the costs would probably be if chiropractic services were included under Medicare.

As to the incidence of chiropractic care among older persons, the data cited above with respect to the California Old Age Security program is, of course, limited to California. Moreover, the number of licensed chiropractors in proportion to the population is very high in California. The publication *Health Manpower and Health Facilities*,⁷ 1968, of the United States Public Health Service, reports that while the number of licensed chiropractors per 100,000 population for the nation as a whole was 9.9 (as of December 31, 1965) the number per 100,000 in California was 22.2, more than twice the national average.

Accordingly, it is important to obtain some information as to the incidence of chiropractic care among the elderly in the nation generally. Information on this score is available from U.S. Public Health Service publication No. 100-Series-10-No. 28.⁸ For the period July 1963-June 1964, this source reported that, among persons age 65 and over, 2.9% made one or more visits to a chiropractor and the average number of visits per patient, during the survey year, was 5.0. As would be expected, this utilization rate is significantly lower than the average rate under the California Old Age Security program, for which the average, over a 6-month interval, was 3.74%. This national average of 2.9% may, however, be understated. The data was developed by sampling methods and there may be some further bias as a result of non-reporting, for the survey year, as to decedents. It would be most unlikely, however, that the true utilization rate, for the year, could have been any higher than about 3.5%, with an average number of visits per patient, for the year, of 6.0 at most.

III. ESTIMATION OF NET CHANGE IN COST RESULTING FROM INCLUSION OF CHIROPRACTIC SERVICES UNDER MEDICARE

At the very outset, it is essential to recognize that if the Medicare program were "expanded" to include chiropractic services, this would NOT represent an absolute addition to the program of an entirely new area of health care costs for which the program is presently paying nothing. Chiropractic care is in large measure an alternative to other types of professional care which are already included in Medicare, i.e., the services of medical and osteopathic doctors. This is obvious, since for certain types of ailments, any given individual may be just as inclined to seek care from a chiropractor as from, say, a medical doctor; provided only that his decision is not being influenced by such a factor as the absence of coverage under Medicare for chiropractic services. It does not *necessarily* follow, therefore, that net costs under Medicare would increase *at all* if chiropractic services were to be recognized. As already shown, the average total cost per case treated by chiropractic care is significantly lower than the average cost of medical or osteopathic care for similar conditions, ranging probably between 70 and 80% of the medical and osteopathic cost. Consequently, if, as a result of the extension of Medicare coverage to chiropractic services, some persons covered by Medicare who are now using the services of M.D.'s and D.O.'s were to obtain instead the services of D.C.'s for various conditions appropriate to chiropractic care, a net *decrease* in the cost of coverage for these persons would be the expected result.

Any valid and realistic estimate, therefore, of the net change in costs resulting from inclusion of chiropractic services must involve determination of a net balance resulting from offsetting changes. At this point it would be well to catalogue the several areas in which either increases or decreases are likely to occur.

⁷ *Health Manpower and Health Facilities*, 1968, U.S. Public Health Service Publication No. 1509, 1968 Edition. (Table 23, page 50.)

⁸ *Characteristics of Patients of Selected Types of Medical Specialists and Practitioners*, July 1963-June 1964: U.S. Public Health Service Publication No. 1000-Series 10-No. 28. (Table 21, page 38.)

A. Areas likely to contribute to decreases in cost

1. Alternative utilization of chiropractic services in lieu of medical or osteopathic services already being utilized under Medicare.

2. Elimination of hospital costs in those cases which currently involve hospitalization, but which, if treated chiropractically, would not result in hospitalization. An obvious example of this would be cases where hospitalization is utilized and the patient placed under traction by the medical doctor. The same ailment, treated chiropractically, would not involve hospitalization.

3. Elimination of the cost of drugs and biologicals currently administered by physicians as incidentals to professional services, in those cases where alternative chiropractic care of the same condition would involve drugless therapy.

In considering these areas of reduced utilization, however, it must be recognized that, since medical and osteopathic services, as well as hospital beds, are in short supply in many areas, some or all of the *reduction* in utilization resulting from alternative chiropractic care will be absorbed by *increased* utilization by other persons. Even if we assume, however, that released time and facilities will be absorbed 100% by other users, only about 25% of these other users will be Medicare eligibles, since this is roughly the percentage of total health care services being utilized by Medicare eligibles. Accordingly, in the estimates to be presented later in this study, I will assume that only 75% of any savings directly arising from alternative use of chiropractic services will actually count as *net* savings under the Medicare program.

It should be understood, however, that the remaining 25% of the savings regarded as "offset" by increases in utilization on the part of other users must not simply be ignored. For one thing, this means that more total care is being delivered under the Medicare program for the same dollars, which quite obviously represents a desirable improvement in efficiency. Secondly, this *offsetting* utilization is *not* chiropractic cost. It is *other* costs, which occur simply because

B. Areas likely to contribute to increases in cost

utilization of chiropractic services releases facilities which are then available for other users. To evaluate this difference, I will also show what the estimated costs are when full account is taken of the direct reduction in utilization of other services made possible by the expansion of Medicare to include chiropractic services.

1. Expansion of coverage to include chiropractic services currently being utilized by persons eligible for Medicare.

Obviously there are many persons who are currently using chiropractic services in spite of the fact that coverage of such services is excluded under Medicare. Expansion of the program to include chiropractic services would result in direct cost increases in these cases, to the extent charges exceed the \$50 Medicare deductible.

2. Utilization of chiropractic services by persons who are now obtaining no professional care at all for certain ailments, but who would seek chiropractic care if it were covered.

In this particular area, it is rather difficult to find moral justification for the saving of costs by *excluding* chiropractic services, since such exclusion leads to the absence of any professional care at all. In fact, the eventual result of this situation, in many instances, may be a net *increase* in cost, because neglect of the ailment may lead to its aggravation, with eventual expensive medical and hospital treatment. There are many rural and small town areas in the United States where the *only* local professional care available is from a chiropractor, so that the *exclusion* of chiropractic services under Medicare amounts to denial of local professional care of *any kind*, to a considerable number of people.

In this same area, it is pertinent to consider the question of the shortage of physicians. If there are persons who are not currently receiving needed care because of such shortage, and who would avail themselves of chiropractic care if this were covered, there would seem to be a strong moral consideration in support of the inclusion of chiropractic services under Medicare even if some net increase in cost *were* the result.

But let me now turn to the task of making some quantitative evaluation of the net probable effect of each of these areas on Medicare costs. For this purpose, I will draw on an assortment of statistics concerning the *first year* of operation of the Medicare program, presented in a paper⁹ by Dorothy P. Rice, of the Office of Research and Statistics of the Social Security Administration.

⁹ "Current Data From the Medicare Program" by Dorothy P. Rice, Office of Research and Statistics, Social Security Administration. Presented at the Statistics and Medical Care Section meeting of the American Public Health Association, Miami Beach, Florida, October 24, 1967.

A. With respect to costs under part A of medicare:

1. Benefits Paid in 1st Year: \$2.5 billion.
2. Hospital admissions: 5,000,000=263 per each 1000 persons enrolled.
3. Persons hospitalized: 4,000,000 of the 19,000,000 enrolled, or 21%.
4. Average Medicare cost per admission: about \$500.

B. With respect to costs under part B of medicare:

1. Benefits Paid in 1st Year: \$700 million, although Mrs. Rice estimates that over \$1 billion are potentially reimbursable, the difference being due to a "lag" in claim reporting and processing.

2. Persons utilizing services covered under Part B: About 12 million during each 6 month interval. [Probably during the entire 12 month period about 16,000,000 persons utilized such services.]

In the first 6 months, about 4 million persons, or 34% of those utilizing Part B services, exceeded the \$50 deductible. In the second 6 months, over 5 million persons, or about 44% of those utilizing Part B services, exceeded the \$50 deductible. [The second 6 months ended as of July 1, 1967, so for the full calendar year of 1967 the percentage would have continued to rise above 44%, since the \$50 deductible applies to the calendar year.]

Now let us construct an estimated profile of chiropractic charges and utilization, if such services were included in Part B of Medicare.

Under the California Old Age Security program, it has been shown (page 5 of this report) that, on the average, about 3.74% of those eligible utilized chiropractic services in each 6 month period. A reasonable assumption would be that over a full calendar year about 5% would utilize such services.

For the nation as a whole, utilizing data developed by the U.S. Public Health Service, I have estimated (top of page 7 of this report) a *maximum* likely rate of utilization to be 3.5%, with a ratio of licensed chiropractors per each 100,000 population less than half of that in California alone. The California utilization rate, however, is among persons *covered* for chiropractic services under a government program, whereas this would not be the case with this national utilization rate. If elderly persons *nationally* were covered under Medicare, one would, of course, expect some increase in the total utilization, even though Medicare coverage involves a \$50 calendar year deductible and provides 80% coverage thereafter. Accordingly, it would seem unreasonable to assume a maximum utilization rate of any more than about 4% nationally, in relation to the 5% annual rate estimated for California where the number of chiropractors in proportion to the population is more than twice the national average, and where their services are covered *without* a \$50 deductible.

This, then, would mean that out of the approximate number of 19,000,000 persons eligible for Medicare during its first year, 4% or about 760,000 would have utilized chiropractic services over a calendar year period.

This estimate also appears reasonable on other grounds. There are approximately 365,000 medical and osteopathic physicians in the United States. The U.S. Public Health Service estimates, that as of December 31, 1965, there were between 15,000 and 17,000 practicing chiropractic physicians.¹⁰ If we take the upper bound of this estimate, that is, 17,000, the ratio of chiropractors to M.D.'s and D.O.'s is about 4.7%. If the services of chiropractors were used in the same proportion to their numbers as the services of M.D.'s and D.O.'s and an estimated 16,000,000 persons eligible under Medicare utilized the latter at least once during the course of a calendar year, then we obtain 750,000 as the estimated number utilizing chiropractic services, practically the same as the 760,000 estimate. By way of contrast, the data gathered in the Iowa Workmen's Compensation survey (page 2) showed the ratio of the number of back injury cases involving chiropractic treatment to the number involving M.D.'s and D.O.'s to be 18.3%. Here, the nature of the injuries involved is such that a far higher proportion of patients would be expected to obtain chiropractic treatment. Also, Iowa is another state, like California, with a high ratio of chiropractors to population: 21 per 100,000.⁷

To form an estimate of the expected profile of charges, I will utilize the Oregon continuance table profile (page 6), for which, as previously noted, the average cost of \$34.35 is very close to the average of \$33.11 for the California Old Age Security data.

Assuming a 3½% annual increase in costs, which should be reasonably accurate, a cost of \$34 in 1964 becomes \$40 in 1969. Also, we need a calendar year figure, rather than per case, and a reasonable maximum adjustment is to increase

¹⁰ *Health Manpower and Health Facilities, 1968 (op. cit.)*, page 49.

the \$40 by 50% to convert it to a calendar year figure, which thus becomes \$60. Finally, the California program was subject to a Schedule of Maximum Allowances as to chiropractic services, and without this fixed schedule limitation on fees, the costs would have ranged about 20% higher. Thus our \$60 becomes \$72. This figure is 210% of the \$34 average for the Oregon data, and if we assume a proportionate magnification of the continuance table, then about 45%, rather than 18.5%, of the total charges will fall in excess of a \$50 deductible on a calendar year basis. In other words, if *no other* Part B charges were incurred by a person eligible under Medicare in addition to chiropractic charges, then the average Medicare benefit payable over a calendar year would be $80\% \times 45\% \times \72.00 , or \$27.50, assuming 100% of the charges to be deemed "reasonable", and thus eligible for payment as provided under the Medicare rules.

I have already shown that chiropractic services may be assumed to average between 70 and 80% of the average cost of the services of M.D.'s and D.O.'s for the same ailment, so, using a figure of 75%, the average M.D.-D.O. cost corresponding to the \$72 D.C. average arrived at above is \$96. Mrs. Rice's paper⁹ show the average recorded *bill* for physician's services to be \$77, so on a calendar year basis my \$96 estimate seems quite reasonable.

For a \$96 average for physician's services, approximately 60% of these total calendar year charges would fall in excess of a \$50 calendar year deductible, so that, for a person incurring only *physician's* services over a calendar year, the average Medicare Part B benefit would be $80\% \times 60\% \times \96.00 , or \$46 per person utilizing only physician's services (which would be about \$740,000,000 per year, for the 16,000,000 persons I have estimated to utilize Part B of Medicare in its first year, not unreasonable in relation to Mrs. Rice's figures).

We are now ready to estimate the total *net change* in cost arising from expansion of Medicare coverage to include the chiropractic services utilized by the estimated 760,000 persons who would utilize such services (based, for the moment, on the number of persons eligible in the first year of Medicare).

Approximately 3,000,000 of the 19,000,000 persons enrolled in the first year of Medicare, or 16% of them, did not utilize any Part B services. Since about 18,000,000 actually enrolled for Part B, 1,000,000 of these were not covered under Part B in any case. Included in this 3,000,000 who did not utilize Part B would be that fraction of the 760,000 persons who were currently using chiropractic services, even though excluded from Medicare, and who were not utilizing any type of Part B service. It is reasonable to assume that this fraction is a higher percentage of the 760,000 than the 16% figure just mentioned, although it can hardly be drastically greater. A reasonable estimate would be that this fraction constitutes about 30% of the 760,000.

I estimated earlier that a national utilization rate among persons 65 and older for chiropractic services should not exceed 3.5%, and I estimated further that this could hardly be expected to rise any higher than about 4% if chiropractic services were included under Medicare. This represents a 15% increase, so we can reasonably expect that another 4.5% ($15\% \times 30\%$) of the 760,000 persons would use chiropractic services if they were covered, in lieu of other more expensive or less accessible professional care now covered by Part B of Medicare, and that this group, likewise, would in such event not also be utilizing other Part B services as well.

The remaining 65.5% of the 760,000 would then be utilizing both chiropractic and other Part B services, if the former were not excluded from Medicare, and a reasonable assumption is that this group would also divide in the ratio of 100 to 15 (that is, in the same ratio as I developed in the immediately preceding paragraph, in estimating the increase in chiropractic utilization if Medicare were to provide coverage) between those who are currently utilizing chiropractic services, in spite of their exclusion from Part B and, on the other hand, those who would avail themselves of chiropractic care as a partial alternative to other professional care, if only it were not excluded from Part B.

The 760,000 persons would then be distributed as follows:

(a) 30%, or 228,000, were those who were using chiropractic services currently, even though not included in Medicare, and, moreover, who were not utilizing any other type of Part B service. One-third of these, however, or 76,000, were not enrolled for Part B.

(b) 4.5% or 34,000, were those who were using the services of M.D.'s or D.O.'s covered under Medicare, but who would utilize chiropractic services for the same ailments, if covered; and, moreover, were not utilizing any other type of Part B service.

(c) 57% or 433,000, were those corresponding to group (a), but who would *also* utilize other Part B services.

(d) 8.5%, or 65,000, were those corresponding to group (b), but who would *also* make partial utilization of other Part B services.

Thus far, we have taken into account 1969 *cost* levels, but not the 1969 enrolled population, since the 760,000 figure above is based on the 18,000,000 persons enrolled for Part B of Medicare in its *first year*. The number enrolled in 1969 is approximately 19,000,000, an increase of 5.5%, so the 760,000 must be increased by 5.5%, as well as each of the 4 population figures (a), (b), (c) and (d) above. These figures thus become:

(a) 241,000, of which 80,000 are not covered, leaving 161,000.

(b) 36,000.

(c) 457,000.

(d) 69,000.

Total 803,000.

For group (a), the Medicare benefit cost would be $\$27.70 \times 161,000$, or \$4,450,000, and this would be 100% net increase in Medicare cost.

For group (b), the *present* cost of Medicare benefits, at an estimated \$46 per person utilizing physicians' services, is $\$46 \times 36,000$, or \$1,650,000, and we assume that 75% of this, or \$1,240,000 would actually be saved under Part B. If chiropractic care were covered under Medicare, the cost would be, instead, $\$27.70 \times 36,000$, or \$997,000. Thus group (b) would produce a net *decrease* in Medicare costs of the difference, or \$243,000. If we count 100% of the savings, as discussed earlier, the net decrease for group (b) is \$653,000.

For group (c), we must assume that a much higher percentage of cost falls in excess of the \$50 deductible, since *other* Part B costs are *also* being incurred. The percentage will fall *between* 45% and 100%, since *some* of it will apply against the \$50 deductible. An assumption of 80% is a reasonable estimate that should not *understate* this cost, so for this group the cost would be:

$80\% \times 80\% \times \$72.00 \times 457,000$, or \$21,100,000, and all of this is net *increase*.

For group (d) the cost, if chiropractic services were covered, would be $80\% \times 80\% \times \$72.00 \times 69,000$, or \$3,180,000. However, under the existing program, let us assume that 85% of the substituted physicians' charges fall in excess of the \$50 deductible after counting the remaining Part B charges, in which case the present actual cost for alternate care of these same ailments comes to:

$80\% \times 85\% \times \$96.00 \times 69,000$, or \$4,447,000, and we assume that only 75% of this, or \$3,340,000, will actually be saved under Part B.

Group (d), then, produces a net *decrease* of the difference between \$3,340,000 and \$3,180,000, or \$160,000. Again, if we count 100% of the savings, the net decrease is \$1,267,000.

The net change for the 4 groups combined is:

	Counting 75 percent of savings	Counting 100 percent of savings
Group (a).....	+\$4, 450, 000	+\$4, 450, 000
Group (b).....	-243, 000	-653, 000
Group (c).....	+21, 100, 000	+21, 100, 000
Group (d).....	-160, 000	-1, 267, 000
Net increase.....	25, 147, 000	23, 630, 000

For Part B alone, the "75% savings" figure is a net increase of just about 11 cents per month per enrollee, and under the Part B allocation formula, this cost is divided evenly between the Government and the participant, or 5.5 cents per month for each. If any margin exists at all in the monthly premium of \$4.00 per enrollee (matched equally by the Government), this premium should be able easily to absorb such a minor increase, which is 1.38% of the \$4.00 contribution rate. The "100% savings figure equals 10.4 cents per month per enrollee or 4.9 cents each for Government and participant.

We should not stop with this, because, as mentioned earlier, there are other areas of cost *decrease* to consider. A significant one is the matter of hospitalization costs that would be eliminated among those in Groups (b) and (d) who would use chiropractic care as an alternative.

Under the present program, I have cited Mrs. Rice's statistics that 4,000,000 covered persons were hospitalized during the first year of Medicare. Under my estimate of a total of 16,000,000 utilizing physicians' services during the first Medicare year, we have 1 out of every 4 persons using physicians' services becoming hospitalized. For the 105,000 persons in groups (b) and (d), a conservative assumption will be that a considerably *smaller* ratio of them would have become hospitalized under the present program but would *not* have been hospitalized under chiropractic care. The reason for this is that we are considering here people who, for the most part, would not be disabled by critically severe conditions necessitating major surgery and the like, so a smaller proportion of this group would become hospitalized under the *existing* program. Let us assume only a quarter of the ratio: 1 out of 16. Let us, moreover, assume that among these the average Medicare cost per admission is only one-half the overall average reported by Mrs. Rice, or \$250 instead of \$500, again due to the milder nature of their conditions. Then the *eliminated* Medicare hospital cost, among these 105,000 persons, is:

$\frac{1}{4} \times 105,000 \times \250.00 , or \$1,640,000. Again, we count only 75% of this as actual net savings, or \$1,220,000.

This projected savings of \$1,220,000, which would develop under Part A of Medicare, would therefore be a 100% offset against the Government's Part A disbursements from the Hospital Insurance Trust Fund, and the net increase in cost, to the Federal Government, would thus be \$12,573,000 (its share of the net increase under Part B) less this \$1,220,000, or \$11,353,000, which comes to about 4.98 cents per month per Part B enrollee. Counting the savings on a 100% basis, the net increase to the Government is \$11,815,000 less \$1,640,000, or \$10,175,000, which is 4.46 cents per month per enrollee.

There are, furthermore, still other areas of decrease; most obviously, outpatient diagnostic charges. We have considered enough, however, to clearly establish the conclusion that even under reasonably conservative actuarial assumptions, expansion of Medicare to include chiropractic services can hardly result in a net increase in costs to the Government of any more than about 5 cents per month per enrollee.

It is my understanding that some estimates of the increased cost of including chiropractic services in Medicare have ranged as high as \$60 million annually. The foregoing considerations at least should clearly demonstrate that this is greatly exaggerated. Even if we were to assume *no savings at all* in costs under Part A, and even if we were to assume that every penny of chiropractic charges for the 723,000 estimated enrolled persons fell *in excess* of the \$50 deductible, and further, if we were to assume that not one penny of this cost would offset *any other* costs being incurred by the program, the resulting estimated cost would STILL not exceed:

$80\% \times \$72.00 \times 723,000$, or \$41,700,000 annually.

The \$50 Part B deductible, however, is simply too great a factor to be disregarded, even in projecting a so-called "high cost" estimate. Sufficient conservatism exists in the various assumptions I have made so that a reasonable "high cost" estimate can be obtained simply by ignoring the net "offsetting" items of savings I have taken into account. Thus, considering each of the 4 groups analyzed previously, we would have:

	Number	Cost
Group (a).....	161,000	\$4,450,000
Group (b).....	36,000	997,000
Group (c).....	457,000	21,100,000
Group (d).....	69,000	3,180,000
Total.....	723,000	29,727,000

This amounts to 13 cents per month per Part B enrollee.

IV. CONFIRMATION FROM EXPERIENCE OF COMMERCIAL INSURANCE COMPANIES

It must be recognized that a number of the assumptions I have used in the preceding analysis are partly conjectural and therefore subject to differences of opinion and to some measure of potential error. Accordingly, it is highly desirable to find some independent source of confirmation of the reasonableness of the overall conclusions reached in Section III of the study. Such an independent

source does exist and it may be found in the experience of commercial insurance carriers. In behalf of one of my commercial company clients, I recently had occasion to study this same question, i.e., the cost of extending coverage to chiropractic services, and in connection with this study I interrogated 19 major health insurance writers as to their experience resulting from such extension of coverage. All of these are large carriers, operating in most states, and all have had at least some experience in relation to recognition of chiropractic services, since in several states insurance laws enacted in the last few years have required that carriers recognize chiropractors for any covered services they are legally qualified to perform. The 19 carriers combined, in 1967, wrote health insurance premiums totalling \$3,879,000,000 or 44% of all the commercial health insurance in the United States; so their combined experience represents a large fraction of the total health insurance experience of the country. Several of them are also participants in the administration of the Medicare program.

Here is a summary of the responses of the 19 companies to my inquiry :

(1) 15 out of the 19 companies are now voluntarily recognizing chiropractic services in all states, not only those where they are legally obliged to do so. The majority of these 15 have been following this practice for many years. The remaining 4 are recognizing chiropractors only in the several states where they are legally required to do so.

(2) 9 of the 19 companies reported that they have detected no apparent change in total claim payout which they could attribute to the inclusion of chiropractic services. 2 of the 19 were of the opinion that a slight increase in costs had resulted, although in neither case was this opinion a clearly established statistical fact: it was, rather, an impression based only on general observations. The remaining 8 did not have an answer to the question of *change* in cost, for the most part because their practice of recognizing chiropractors dated back so far that no basis of comparison existed. All of the statistical data of these 8 included coverage of chiropractors for those covered services they are legally qualified to perform.

(3) Of the 4 carriers recognizing chiropractors only in those states where legally required, which requirement has in most such states been of recent enactment, 3 reported *no apparent change in costs* in those states. The 4th did not have an opinion, having not yet analyzed their experience to draw any conclusion on this score.

The general conclusion to be reached from this survey of commercial carriers is that *no significant net change* in costs resulted from their expansion of coverage to chiropractic services. Several of these carriers have large volumes of group hospital and medical insurance in force, and a change of as much as 2% in costs under such programs, resulting from expansion of coverage to a new area of professional services, such as chiropractic, would be "significant". *None* of them were of the opinion that any increase of even these modest proportions had occurred. My "probable maximum" estimate of the net increase in costs under Part B alone, for 1969, is 11 cents per month per enrollee (page 14 of this report). This represents approximately 1.4% of the \$8.00 per month contributed by the Government and each enrollee, combined, and is of about the size, percentage-wise, where a large commercial group writer would begin to take definite note of its presence in total cost allocations. In short, the experience of commercial carriers would support the conclusion that my estimate is *conservative*, and that the probability is that the actual costs of chiropractic care under a program such as Part B of Medicare will be *less* than what I have projected.

It must be recognized that some of the *coverage* which the 19 large carriers have in force would provide only *limited* coverage of chiropractic services. For example, hospital-surgical policies covering only "in-hospital" physicians' visits would provide essentially no chiropractic coverage at all. On the other hand, however, comprehensive medical policies with low deductibles would provide broad coverage of chiropractic charges, and on a basis quite similar to Medicare, with deductibles such as \$50 per calendar year, etc. Some of these carriers have very substantial volumes of this type of coverage in force. If these carriers have detected *no* apparent increase in claim costs resulting from recognition of chiropractors, it seems most likely that *little* increase will result under Medicare either. a result consistent with what I have projected in the calculations summarized in Section III of this study.

V. SUMMARY OF CONCLUSIONS

By way of summarizing the various considerations I have attempted to evaluate, I obtain the following as estimates of what the cost would have been, during the year 1969, if chiropractic services were covered under Medicare:

PROJECTED MONTHLY COST, PER PART B ENROLLEE, OF CHIROPRACTIC SERVICES
INCLUDED IN MEDICARE DURING 1969

1. "High cost" estimate, taking no account whatever of any offsetting savings in existing Medicare payments: 13 cents. [Page 15 of this study]

Since the cost of Part B is divided equally between the Federal Government and the individual participants, the Government's share of this high cost estimate is 6.5 cents.

2. "Probable maximum" estimate for Part B alone, taking account only of the likely actual net savings in other Part B payments: 11 cents. [Page 14 of this study]

The Federal Government's share would be 5.5 cents.

3. "Probable maximum" estimate of the net increase in costs under Parts A and B combined, taking account of likely actual net savings under *both*: 10.5 cents.

The Federal Government's share, as the net difference between its Part B cost and the savings to the Part A Trust Fund, is 4.98 cents. [Page 15 of this study]

4. "Low cost" estimate, taking full account of the offsetting savings arising *directly* from the shift to alternate chiropractic care: 9.6 cents.

The Federal Government's share, as the net difference between its Part B cost and the savings to the Part A Trust Fund, is 4.46 cents. [Page 15 of this study]

APPENDIX A

CRITIQUE OF ACTUARIAL COST ESTIMATE ON CHIROPRACTIC SERVICES UNDER MEDICARE PREPARED BY ACTUARIAL DIVISION OF SOCIAL SECURITY ADMINISTRATION

The cost estimates which I have developed in the preceding study are much lower than estimates developed by the Actuarial Division of the Social Security Administration. The latter are presented in a memorandum from Mr. William Hsiao, F.S.A. to Mr. Robert J. Myers, Chief Actuary of the Actuarial Division of S.S.A., dated February 13, 1969.

By way of presenting a concise comparison between the two studies, here is a summary of the conclusions.

Mr. Hsiao made two determinations of the estimated cost, using two separate approaches, as follows:

1. An estimate based on gross annual income of chiropractors, together with the percentage of this income assumed to be derived from persons over 65. The assumptions are:

- a. Number of chiropractors in private practice: 23,000.
- b. Average gross income in 1969: \$19,000.
- c. Percentage of this income assumed to derive from patients 65 and older: 23.1%.
- d. Percentage of (c) remaining after deducting the \$50 Part B deductible and the 20% "coinsurance" under Part B: 63%.

These 4 assumptions lead to the calculation

$$23,000 \times \$19,000 \times 23.1\% \times 63\% = \$63,600,000$$

as the estimated *benefit cost*.

Administrative expenses are assumed to be 11.5%, so total cost is projected as

$$\$63,600,000 \times 111.5\%, \text{ or } \$70,900,000$$

which is 31 cents per month per enrollee.

2. An estimate based on utilization rates and cost per visit. The assumptions are:

- a. Percentage of aged population utilizing chiropractic services when *not* reimbursable under SMI—4½%.
- b. Additional 1 to 1½% assumed to utilize when covered by SMI, but cost offset by corresponding decrease in utilization of "physicians". (i.e., no change on this account.)
- c. Utilization rate: 12 visits per year per patient.
- d. Average cost per visit: \$7.

- e. Percentage remaining after deducting deductible and coinsurance : 63%.

These assumptions lead to the calculation

$$19,000,000 \text{ (population enrolled)} \times 4\frac{1}{2} \times 12 \times \$7 \times 63\%$$

$$=\$45,200,000$$

as the estimated *benefit cost*.

Again, adding administrative expense of 11.5%, the total cost is projected as

$$\$45,200,000 \times 11.5\%, \text{ or } \$50,400,000$$

which is 22 cents per month per enrollee.

My study does NOT attempt to measure administrative cost, since I have no information on this score (other than Mr. Hsiao's 11.5%). My only comment is that 11.5% seems excessively high, since large commercial insurance carriers are known to be able to administer large group medical benefit plans for as little as 4 or 5%, and I find it remarkable that the administrative costs under Part B of Medicare should prove to be as high as 11.5%. Nevertheless, I will not attempt to delve further into the question of costs of Federal administration. To make the estimates of the two studies fully comparable, we should therefore consider *benefit costs* only, which are what my study undertakes to evaluate, and these, to recapitulate, are as follows :

SSA Estimate :

Method 1 : \$63,600,000, or 28 cents/mo./enrollee.

Method 2 : \$45,200,000, or 19.8 cents/mo./enrollee.

From these two estimates, Mr. Hsiao concludes that a figure half-way in between, or about 34 cents/mo./enrollee (26 cents including administrative cost) is the "most probable" additional cost to include chiropractic services.

My estimates were as follows :

1. "High cost" : \$29,727,000, or 13 cents/mo./enrollee.

2. "Probable Maximum", Part B alone : \$25,147,000, or 11 cents/mo./enrollee.

3. "Probable Maximum", A and B combined : \$23,927,000, or 10.5 cents/mo./enrollee.

4. "Low cost" : \$21,990,000, or 9.6 cents/mo./enrollee.

My basic estimate is No. 2, 11 cents per month, *less than half* Mr. Hsiao's concluding 24 cent estimate. In view of this very drastic difference in estimates, some comment is in order as to what factors may account for this large difference.

The significant factors are as follows :

1. Mr. Hsiao uses 23,000 as his estimate of the "number of chiropractors in private practice". His source for this figure is "Health Resources Statistics, 1965", *Public Health Service Publication No. 1509*.

A later edition of this same publication, however, "Health Resources Statistics, 1968", *Public Health Service Publication No. 1509* (1968 Edition) states, on page 49 :

"About 19,100 chiropractors were licensed at the end of 1965 in the United States, according to estimates based on a survey published in the American Chiropractic Association's Journal of Chiropractic (table 23). Of the 19,100 chiropractors, licensed in 1965 in the United States, perhaps 15,000 to 17,000 were actively engaged in practice at that time. This is substantially less than had been estimated in the earlier edition of this publication."

Thus, at the very outset, using Mr. Hsiao's own source of information, we must conclude that a figure of 17,000, at most, rather than 23,000, is appropriate. This *alone* will reduce Mr. Hsiao's method 1 result by 26%.

2. Under both methods 1 and 2, Mr. Hsiao assumes that 63% of chiropractic charges will remain as reimbursable after subtracting the \$50 Deductible and the 20% coinsurance. He gives no *direct* justification for this assumption at all, stating merely that "A reasonable assumption is that 63% of the chiropractor's charges to SMI enrollees will be reimbursed by the Medicare program".

The indirect justification offered for this very broad assumption is as follows :

He states that "the Current Medicare Survey shows that among the SMI enrollees who utilized covered services in 1967, 63% of the incurred costs are potentially reimbursable after taken into account of [sic] deductible and coinsurance", and adds, "Because of the increase in physicians' fees and utilization, we would expect a larger percentage of the incurred costs to be potentially reimbursable in 1969. On the other hand, we know from actual experience that many enrollees do not file claims for one reason or another". Elsewhere, he states that "the fees charged by the chiropractors as compared with physician's fees in performing similar services might be approximately 10% less".

Now, even using this "10% less", Mr. Hsiao should logically come to the conclusion that, if 63% of *M.D.* and *D.O.* incurred costs were "potentially reimbursable" [note that he does NOT say "actually reimbursed"] in 1967, *then something less than 63%* of chiropractic charges would have been "potentially reimbursable". This is the conclusion one *has* to reach, if chiropractic charges "might be approximately 10% less". If they are 10% less, then a *lesser* fraction than 63% will *necessarily* remain after subtracting the \$50 Deductible and 20% of what exceeds this Deductible. But this "10% less" is not the whole story by any means. As pointed out in my own study (page 4), comparative costs must be determined in relation to *average total cost of treatment*, NOT on the basis simply of average charge per office visit, as used by Mr. Hsiao in arriving at his "10% less". My own study develops, at considerable length, justification for the conclusion that the ratio of chiropractic total costs to *M.D.* and *D.O.* total costs fall between 70 and 80%. I further develop, in considerable detail, a basis for estimating what fraction of chiropractic costs may be expected to exceed the \$50 Medicare Part B deductible (see pages 6 and 7, and subsequently pages 11 and 13). I was led to the conclusion that, in the absence of *other* Part B services, 45% of chiropractic costs would exceed the \$50 deductible and 80% of *this* would be reimbursable, or 36%, compared to Mr. Hsiao's 63%.

Among persons incurring *other* Part B expenses, I concluded that 80% of chiropractic costs would exceed the \$50 deductible, so with 80% of this reimbursable we have 64%, close to Hsiao's 63% for this *portion* of the utilizing population, but only by coincidence.

I provide extensive analysis and support for my percentages, whereas Mr. Hsiao's supporting discussion actually *contradicts* his conclusion, since the same 63% can hardly be valid for *both* chiropractic charges and also presently reimbursable charges if the former average "10% less". *Charges* which are 10% less would *necessarily* result in a lesser fraction than 63% remaining reimbursable above the \$50 Deductible.

Based on my own analysis, and the relative numbers involved in each of my population categories (page 12), one can reasonably conclude that a *composite* percentage for all enrollees utilizing chiropractic services would be close to:

$(34.5\% \times 36\%) + (65.5\% \times 64\%)$, or 54%, as a conservative estimate.

Adjustment of Mr. Hsiao's 63% to this rather more supportable figure of 54% would reduce *both* his method 1 and method 2 estimates by 14.3%, without considering *any* of the other adjustments needed. Finally, this 54% remains as a "potentially reimbursable" estimate, rather than an estimate of what would be "actually reimbursed".

3. In his method 2, Mr. Hsiao adopts, as his estimate of the number of visits per year per patient, 12. For his derivation of this, he refers us to page 4 of his memorandum, where he begins, "In this area, there is very little data", and cites 3 sources:

(a) The Batten and Associates' study (my footnote 4), which showed an "average number of treatments per patient in 1962 as 10". Mr. Hsiao continues "it is unclear in that report whether this average is on a calendar year basis or is per illness". As a matter of fact, it is not clear that *either* is meant by the Batten report. All it says is "average number of treatments per patient". Over 30% of the respondents (chiropractors surveyed by mail) reported 6 or fewer visits per patient. More than 17%, on the other hand, reported over 20 visits per patient. This suggests that the respondents themselves did not all have the same parameter in mind in their answers (some may well have meant "total treatment *history* per average patient"), which leaves this whole source highly suspect.

Mr. Hsiao finally adds the comment, "from public health data, we know the aged population make $\frac{1}{3}$ more visits to physicians than people under age 65". (Source: "Volume of Physician Visits, United States—July 1966—June 1967": National Center for Health Statistics, Series 10, No. 49.) This data pertains to physicians' visits in general, not to *chiropractic* visits as such.

As to his sources, Mr. Hsiao completely neglects another pertinent U.S. Public Health Service publication to which he does, however, refer elsewhere in his memorandum. This is Public Health Service Publication No. 1000, Series 10, No. 28, to which he refers on page 3 of his memo, where he comments that it "showed approximately 2.9% of the aged population had utilized some chiropractic services during the period July 1963 through June 1964". The 2.9% figure appears on page 38 of the report. On the opposite page (page 39), the report *also* shows

that among persons 65 and older the "number of visits per patient per year" was 5.0 (less than *half* of the average number, 12, eventually assumed by Mr. Hsiao).

(b) California Old-Age Security data, wherein the average number of visits to a chiropractor in a 6-month period was 7.

As pointed out in my study (page 6), the ratio of chiropractors to population in California is more than twice the national average. Further, the data cited are developed under a public aid program that involves *no deductible at all*. Consequently, I cannot accept this "7 per 6 months" statistic as very indicative of the expected number per year under Part B Medicare enrollees if chiropractic services were covered.

(c) My own earlier study of June 1968, citing data published by the Florida Chiropractic Association in 1960, which showed the "average number of treatments per case" with respect to sprains and strains of the neck, spinal vertebrae and external back, to be 9. This data, dealing as it does with a very narrowly circumscribed category of ailments, can hardly be taken as indicative of the average number of visits, *for all causes*, to chiropractors on the part of persons over 65 in general.

Elsewhere in his own memorandum, Mr. Hsiao himself quotes another pertinent statistic, which he does not appear to have considered in deriving his estimate of 12 visits. On page 5, under "Aggregate Cost" he refers to a "Current Medicare Survey" which showed that enrollees under SMI had utilized chiropractic services amounting to \$19,978,000 during a 9-month period in 1967 and 1968. He adds "Interestingly enough, the average number of visits per patient for this 9-month period was only 3.9." If expanded, proportionately, to 12 months, the 3.9 becomes 5.2, highly consistent with the 5.0 cited by Public Health Service Publication No. 1000, Series 10, No. 28. Thus what would appear to me to have been the two most pertinent and reliable sources of data available to Mr. Hsiao on this specific point are *both ignored* and also *both closely consistent*: 5.0 visits and 5.2 visits, respectively. It seems extremely unlikely that, as a result of the extension of \$50 Deductible Part B Medicare coverage to chiropractic service, this rate of 5 visits per year could possibly rise to any more than about 7.

My own conclusion from all this, then, is that a more realistic upper estimate of the number of visits per year to be anticipated under Medicare would be about 7, rather than 12. Adjustment of this figure *alone*, disregarding all the other adjustments I suggest should be made, would reduce Mr. Hsiao's method 2 cost estimate by a whopping 42%.

4. Under method 1, Mr. Hsiao assumes that 23.1% of the gross income of chiropractors will derive from patients age 65 and over. His source for this is data limited to California (page 4 of his memorandum). This was data compiled by the Stanford Research Institute which Mr. Hsiao states "concluded that almost 33% of the chiropractic patients were people 60 years of age and older." He then adjusts the 33% to 23.1% (page 12 of his memo) by using general population ratios to screen out the 60-64 age group.

As an independent test of the validity of this procedure (which again involves the questionable process of applying *California* percentages to the nation as a whole), let me once again refer to Public Health Service Publication No. 1000—Series 10, No. 28. If we consider *number of patients* (Table 21) we find from this particular source that approximately 11.7% of all chiropractic *patients* were persons age 65 or over (for the year July 1963–June 1964).

If we consider *number of visits* (obviously a better index of the proportion of *total care* and hence *total income* deriving from persons age 65 and over than number of *patients* only) we find from this source (Table 22) that approximately 12.6% of all *visits* to chiropractors were made by persons age 65 or older. This is a long way from Mr. Hsiao's 23.1%. The 12.6%, however, should be adjusted for the expected increase in Medicare covered utilization of chiropractic services. Making this adjustment, consistently with equivalent adjustments made in my study to account for this, we increase the number of patients by 15% and the number of visits per patient by about one-third, obtaining:

$$12.6\% \times 1.15 \times 1.33 = 19.2\%.$$

If Mr. Hsiao's 23.1% is modified to this 19.2% which is actually *based* on national data from the Public Health Service figures, his method 1 result, disregarding *all other* adjustments, would reduce by 17%.

5. In method 2, Mr. Hsiao adopts, as his estimate of the fraction of persons age 65 or over who utilize chiropractic services, *without* Medicare coverage, $4\frac{1}{2}\%$. My

own study arrives at 3½% (page 6), increasing this to 4% (page 9) as a result of extension of Part B coverage to chiropractic services.

As support for his 4½% assumption, Mr. Hsiao cites the following (page 3 of his memo) :

(a) Again, PHS Publication No. 1000, Series 10, No. 28, to which reference has been made several times. As previously mentioned, this showed 2.9% of the aged population utilizing some chiropractic services over a 1 year period. Mr. Hsiao adds, "However, this survey omitted one important group, decedents. From prior experience, the adjustment for decedents can be as high as 40%-50%". A full 50% adjustment would blow the 2.9% up to 4.35%. However, while such a pronounced adjustment could well be called for as to M.D. attendance upon aged individuals I find it inconceivable that any comparable adjustment would be appropriate for chiropractic care, assuming as it does a heavy attendance by chiropractors upon terminal illnesses among the aged. My own adjustment of this figure to 3.5% seems much more within realistic bounds.

(b) The California Old-Age Security data, showing an average 3.74% utilization each 6 months. I have estimated that adjustment of this rate to a 12-month basis would raise it to 5%. However, as I have pointed out previously, this data relates (1) to a state where the ratio of chiropractors to population is more than twice the national average, and (2) to utilization under a government program with *no deductible at all*. If the existence of Medicare coverage, with a \$50 calendar year deductible, can be expected to *increase* utilization of chiropractic services, then coverage under a *no deductible* program would surely increase it even more. I therefore find it unreasonable to assume, on the support of this California data, that the national utilization rate, *without* governmental coverage should be as high as 4½%.

(c) A "Current Medicare Survey" which Mr. Hsiao states was conducted by the Bureau of the Census for the Social Security Administration in February, 1969. Mr. Hsiao tells us that this source showed that in the 9 month period October 1967 through June 1968, 5.4% of SMI enrollees utilized chiropractic services even though excluded from Medicare. If so, this would indeed suggest that 4½% is not an excessive estimate. However, this 5.4% figure (over 9 months) is highly inconsistent with the PHS Publication 1000 figure of 2.9% over 12 months, and, in my opinion, also seems most unlikely in relation to the California Old Age Security data. It would be of interest to know more about this "Current Medicare Survey" and its methodology; however, upon inquiry I learn that this Survey was never published. Apparently, it was a special tabulation made for SSA use and is unavailable.

In the absence of more convincing supporting data to the contrary, I find my 3½% estimate going to 4% in the presence of Medicare coverage assumed to include chiropractic services, to be considerably more realistic and supportable. However, as I will show shortly, even if we *accept* Mr. Hsiao's 4½%, adjustment of his calculations in relation to the first 4 factors discussed above will bring his figures well down into the range of my own benefit cost estimates.

6. In method 1, Mr. Hsiao assumes that the average gross income of chiropractors in 1969 is \$19,000. His support for this assumption goes back to the Batten and Associates' study of 1962, which reported average gross income of \$14,000. To arrive at \$19,000 in 1969, Mr. Hsiao applies a 36% increase, "according to the physician's fee component of Consumer Price Index". I regard this 36% factor as rather questionable on the basis of Mr. Hsiao's own findings (pages 9 and 10 of his memo) that there is "unused capacity" among the chiropractors. He also comments (page 9) that "today, the utilization of physicians' services has largely been held down by the scarcity of medical doctors". Simple operation of the economic law of supply and demand would suggest that the fees and incomes of medical doctors would have increased, over the 7 years, by a larger percentage than those of chiropractors. Other than regarding it as a dubious figure, however, let us accept the \$19,000 gross income figure. As I've mentioned, adjustment on account of the first 4 factors alone, discussed above, will bring Mr. Hsiao's estimates into reasonable consistency with the cost estimates of my own study.

7. Mr. Hsiao devotes a considerable portion of his memorandum to the subject of the training and qualifications of chiropractors and the scope of illnesses treated by them, and concludes from his discussion (page 9) "that the fair and reasonable approach is to assume that any factors which tend to increase the cost will be offset by the factors which tend to reduce the cost". He cites, as considerations tending to increase the ultimate costs resulting from chiropractic care, the following :

(a) Page 7: "Questions have been frequently raised as to whether chiropractors have the training and qualifications to be a substitutive form *for all types* of physicians' services." [*italics mine*] To begin with, I am not aware that anyone is *suggesting* substitution "for all types" of physicians' services. In my study, I have merely taken it for granted that chiropractors, under Medicare, would perform services within customary range of their practice and which they are *legally licensed to perform*. I make no pretense of evaluating any further the relative *efficacy* of chiropractic care as compared to care by medical or osteopathic doctors—one way or the other. I know of no statistics available by which one may make any such evaluation, and, since Mr. Hsiao cites no such statistics, I presume he knows of none either.

Apparently Mr. Hsiao assumes that chiropractors generally undertake to treat every form of illness, on the basis of information in the Batten and Associates study (page 2 of his memorandum) which indicated that chiropractors reported having treated a very wide range of conditions. I note, for example, that 9% reported "having treated" fractures; 7% reported "having treated" cancer. I find it extremely difficult to determine what meaning, if any, to ascribe to such information. I derive somewhat more significance from another chart in the Batten Study entitled "Illnesses Most Frequently Treated". The six "most frequent" together with the frequency index used in the Batten Study, are:

Headache	2, 009
Lumbo-sacral strain or sprain.....	1, 645
Low back disorders.....	1, 629
Cervical subluxations (neck, head)	1, 558
Spinal subluxations.....	957
Sacro-iliac strains.....	868

Among the conditions cited by Mr. Hsiao as having been treated by a very large percentage of chiropractors are the following:

	Percent
Sinusitis	94
Constipation	94
High blood pressure.....	93
Asthma	89
Bronchitis	86
Gall bladder.....	82
Ulcers	76

These same 7 conditions, in the scale of "Most Frequently Treated" illnesses, show the following frequency indexes:

Sinusitis	284
Constipation	87
High blood pressure.....	167
Asthma	140
Bronchitis	17
Gall bladder.....	61
Ulcers	26

Thus, as to *frequency* of treatment, these 7 conditions each tend to develop, as a rough average, about 6 or 7% of the average frequency of each of the top six, even though 76 to 94% of chiropractors reported "having treated" them.

Also of interest are the following observations:

(1) Mr. Hsiao states "the method of obtaining these diagnoses is unknown", and elsewhere says "the results from possible incorrect diagnosis and treatment might require some patients to be hospitalized, whereas the need might not arise if they were under the care of physicians". Since, in Mr. Hsiao's opinion, chiropractors have dubious qualifications even to diagnose correctly many of his listed conditions, one wonders why he implies that the *list* of conditions treated holds any real significance in the first place.

(2) As mentioned in my study (page 8), there are a good many rural and small town localities where the only local practitioner *available* is a chiropractor. In view of this fact, it is hardly surprising that we find chiropractors reporting "treatment" of a pretty wide range of conditions, including an interesting one not mentioned by Mr. Hsiao: obstetric service, for which 7% of chiropractors report having given "treatment".

(b) Page 8: "In many cases, the wrong diagnosis might be made or incorrect treatments given. The patients' conditions will be aggravated and might require more expensive treatments or hospitalization. This will increase the cost of the Medicare program." Again, on page 9: "the results from possible incorrect diagnosis and treatment might require some patients to be hospitalized, whereas the need might not arise if they were under the care of physicians."

Mr. Hsiao goes on to concede (page 9): "there is no "direct" [quotes mine] statistical information *whatsoever* [italics mine] to shed any light on this question."

Which is precisely the point. Mr. Hsiao admits he has no statistical evidence "whatsoever". Nor does he suggest what "indirect" evidence throws any real light on the matter, either. He is merely theorizing. Accordingly, I question that he really has any justification at all for concluding that these influences *will*, in fact, *offset* other influences for which *we do* have statistical evidence indicating they do produce cost savings. He does, specifically, assume that such an offset *will* occur, as a "fair and reasonable" approach. My study, for example (pages 1-4) presents considerable *statistical evidence* that in the specific area of sprains and strains of the back, chiropractic total treatment costs are *less* than treatment by M.D.'s and D.O.'s. Accordingly, in the light of known statistical evidence on this score, and the total absence of statistical evidence of *any kind* supporting Mr. Hsiao's theories about the relative efficacy of chiropractic care, I feel justified in assuming certain offsetting *savings*, as described in my study.

Our task in these studies, after all, is a *statistical* and *quantitative* one. I do not regard our task as one that extends to that of making evaluations as to the relative adequacy or efficacy of chiropractic care as compared to medical or osteopathic care. My professional competence lies in dealing with statistical data and actuarial probabilities—not in evaluating the relative potency of different forms of legally licensed health care services.

Let me now adjust Mr. Hsiao's calculations in relation to the first four only, of the seven factors I have discussed. These were:

(1) 17,000 is a supportable estimate of the number of practicing chiropractors, rather than 23,000.

(2) 54% is a more supportable estimate of the fraction of chiropractic charges "potentially reimbursable" under Medicare than 63%.

(3) 7 is a more supportable estimate of the number of visits per year (under Medicare coverage) than 12.

(19.2% is a more supportable estimate of the percentage of chiropractors' gross income derived from patients 65 and over (in the presence of Medicare coverage) than 23.1%.

If recalculations are made, using these 4 adjustments we obtain:

For Mr. Hsiao's method 1:

$$\begin{aligned}\text{Benefit cost} &= 17,000 \times \$19,000 \times 19.2\% \times 54\% \\ &= \$33,489,000 \text{ vs. his } \$63,600,000\end{aligned}$$

For method 2:

$$\begin{aligned}\text{Benefit cost} &= 19,000,000 \times 4\frac{1}{2}\% \times 7 \text{ visits} \times \$7/\text{visit} \times 54\% \\ &= \$22,623,000 \text{ (vs. his } \$45,200,000)\end{aligned}$$

Using his same concluding assumption, namely that the "most probable additional cost to cover chiropractic services" is simply the arithmetic mean of these two estimates, we conclude with a figure of:

\$28,055,000

This figure is an estimate that *ignores* any "offsetting savings". My comparable estimate is my "High Cost" estimate, No. 1, which is

\$29,727,000

The two are pretty close.

In conclusion, I feel obliged to refer to these comments made in Mr. Hsiao's conclusion:

"The most probable additional cost to cover chiropractic services is estimated to be \$60 million in 1969 . . . This estimate is reasonable in light of the information that the people enrolled under SMI had spent approximately \$27 million for chiropractic services in a recent 12 month period, even though these charges are not reimbursable by the program."

I propose that, in relation to the \$27,000,000 statistic, an estimate of \$60,000,000 is very, very *unreasonable*.

The *benefit cost*, relating to the \$60,000,000, would be net of 11.5% administrative cost and equal to:

\$54,000,000

Since Mr. Hsiao has assumed that 63% of the chiropractic charges incurred are "potentially reimbursable", this \$54,000,000 is only 63% of the assumed *charges*, which in turn means that he has assumed that the SMI enrollees would have *incurred charges* totalling:

\$86,000,000

for chiropractic services if only these had been covered by Medicare.

However, in the *absence* of Medicare coverage, they incurred only \$27,000,000 (this figure being expanded to 12 months from the \$19,978,000 over 9 months, reported by Mr. Hsiao as the finding of the "Current Medicare Survey") of chiropractic charges.

In other words, Mr. Hsiao finds it "reasonable" to conclude that, purely and directly as a result of extending \$50 deductible, 80% coverage Part B of Medicare to include chiropractic services, the SMI enrollees would *increase* their expenditures for chiropractic care by \$59,000,000, or 218%!! In other words, their expenditures for chiropractic care would more than triple, from \$27,000,000 to \$86,000,000!! If such an amazing conclusion is indeed to be deemed "reasonable", then this is a most crucial matter of public policy indeed for Congress to consider, since it would indicate that a substantial portion of the public are being denied health services which they *want* and would *use* to a greatly increased degree if only Congress would recognize these desired services under the Medicare program.

Respectfully submitted.

E. PAUL BARNHART, F.S.A.,
Consulting Actuary.

(The following is the chiropractic's "white paper," dated May 1969, on Health, Education, and Welfare Secretary's report, "Independent Practitioners Under Medicare," dated December 28, 1968. For text of the Secretary's report, see p. 623.)

CHIROPRACTIC'S
"WHITE PAPER"
on
Health, Education and Welfare Secretary's Report
"Independent Practitioners Under Medicare"

American Chiropractic Association, Inc.
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International Chiropractors Association
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May, 1969



(1489)

Synopsis of Selected Statutory Requirements
For Licensure in the
Allied Healing Arts
(Medicine, Osteopathy, Dentistry, Optometry, Podiatry)

The purpose of this study is to review for uniformity or lack of uniformity in statutory requirements of the allied healing arts in the various jurisdictions.

There is a definite lack of uniformity in the statutory definitions of all groups ranging from no definition in some groups to the superfluous use of descriptive adjectives and repetitions in other groups.

Lack of uniformity in license requirements and educational requirements seems to be rather pronounced. Of the fifteen states reviewed, examples noted are:

Medicine--"graduate of approved medical college", "medical college approved by A.M.A. (or Board)", "teaching a course equivalent to University of Wisconsin Medical School", etc. Other college requirements--2 states require 1 year, 4 states require 2 years, 1 state requires 3 years. Internship--7 states require 1 year.

Dentistry--"graduate of recognized dental school", "graduate of reputable school", "dental college approved by A.D.A. (or Board)", etc. Other college requirements found in 2 states--each require 2 years. One state requires a 1 year internship.

Osteopathy--no identification as osteopath in California, credentials must be satisfactory to Medical Board. "graduate of reputable school teaching 4 years of 9 months each", "college approved by A.D.A. (or Board)", graduate of school teaching not less than 4422 hours and approved by A.D.A.", etc. Other college requirements--eight states require 2 years college. Internship--3 states require 1 year, 1 state requires 2 years.

Podiatry--"accredited college", "college recognized by N.C.A.", "requires 4160 hours", "3 years of 8 months", etc. Other college requirements--6 states require 1 year college, 3 states require 2 years college. No internship.

Optometrist--"approved school which requires at least 3 years of study", "accredited optometric college", "graduate of Class A optometric school", "graduate of college teaching no less than 2800 hours", "minimum of 4 years", "5000 hours in 5 years of 8 months each", etc. Other college requirements--2 states require 2 years college, 1 state requires 1 year. No internships.

Basic Science (B.S.) examinations are required of applicants for medical and osteopathic licensure in 10 states--required of podiatrist in one state (Arizona and exempt in others)--dentists and optometrists exempt in all states.

Department of Professional Affairs
American Chiropractic Association
Des Moines, Iowa
Oct/67

OSTEOPATH

STATE	DEFINITION AND/OR SCOPE OF PRACTICE	LICENSE REQUIREMENT	MISCELLANEOUS
Alabama	Not defined.	Graduate of school approved by Board of Medical examiners.	B. S. certificate
Arizona	Licensed to practice medicine and surgery as osteopathic physicians.	Citizen--21 years of age--good moral character--graduate of school approved by A.O.A.--2 year training in Board approved hospital to practice major surgery after exam.	Use of title--D.O., Osteopathic Physician, Osteopathic Physy. & Surgeon, Dr. of Osteopathy--B. S. certificate.
Arkansas	Not defined but declared not to be the practice of medicine.	Graduate of 4 year (9 months each) reputable D.O. school--special examination required by Board of Medical Examiners to prescribe drugs and perform surgery.	Use of title--not defined. B. S. certificate.
California	Licensed as M.D.	Must present credentials satisfactory to medical board.	Can't use term Osteopath.
Delaware	Investigate, diagnose and give surgical assistance to, or suggest, recommend, prescribe or direct for use of any person, any drug, medicine, appliance or other agency for cure or relief or palpitation of any ailment or disease of mind or body.	Age 21--citizen--good moral character--high school graduate--2 years college--graduate of Board approved professional school--1 year internship.	Use of title--D.O. Osteopath.
Florida	The system or school of medicine which is taught and practiced in the standard colleges of osteopathy and surgery.	Age 21--good moral character--no citizen requirement--2 years of college--graduate of professional school teaching at least 4 years (36 months) in all subjects necessary to educate a thoroughly competent osteopathic physician and surgeon--1 year internship in Board approved hospital.	Use of title--not defined. B. S. certificate.

STATE	DEFINITION AND/OR SCOPE OF PRACTICE	LICENSURE REQUIREMENTS	MISCELLANEOUS
Iowa	Treating human ailments by rehabilitating, restoring and maintaining body functions through manual stimulation and inhibition and use of any other therapeutic method, agent or modality. Includes practice of major surgery.	High school graduate--2 year college Practice of osteopathy --graduate of Board approved professional school Practice of Osteopathy and Surgery--same as above plus 2 year P.G. surgery or 1 year P G. and 1 year training as surgical assistant--no age, citizen, or moral character requirements.	Osteopath may practice obstetric and minor surgery. Osteopath cannot do major surgery. B. S. certificate. Use title--Dr. w/D.O. or O.S.
Kansas	Same as M.D.	No age, citizen, moral character requirements -- high school graduate--graduate of approved professional school plus approved internship.	Use titles--D.O., Osteopath, Dr. or Doctor w/appropriate designation--B.S. certificate.
Louisiana	Treatment of disease, infirmity, deformity, defect, ailment or injury human by manipulations applied to nerve centers, bones, muscles or ligaments, without use of drugs or medicine, except antiseptics and anodynes locally applied. No narcotics, obstetrics, gynecology, surgery and no fracture reduction.	No age, citizen or moral character requirements--graduate of professional school requiring 4 years of 9 months each.	Use of titles--D.O., Dr. of Osteopathy, Osteopath, Osteopathic Physician.
Missouri	To practice medicine or surgery in any of its departments, to cure and treat the sick and others afflicted with bodily or mental infirmities, engage in midwifery.	Citizen, good moral character, no age requirement--high school graduate--60 semester hours college--graduation from professional school approved by A.O.A.--4 years of which last 2 years spent in operative and hospital work.	Use of title--Dr., D.O., Doctor Physician
N. Mexico	That complete system or school of medicine and surgery as governed by the Act (as taught and practiced in Osteopathic colleges)	Age 21--good moral character--no citizen requirement--2 years college--graduate of Board approved professional school (requiring attendance of 4 years of 9 months each.)	Use of title--not defined. B. S. certificate.

STATE	DEFINITION AND/OR SCOPE OF PRACTICE	LICENSURE REQUIREMENTS	MISCELLANEOUS
Ohio	Same as M.D. Licensed by Medical Board	Age 21--good moral character--no citizen requirement--high school graduate--2 years college--graduate of Board approved professional school	Use of title--Dr., D.O.
Tennessee	As taught and practiced by recognized associated colleges of Osteopathy. Right to use such drugs as necessary in practice of osteopathy, surgery, and obstetrics, including narcotics, antiseptics, anesthetics, and biologicals.	Age 21--good moral character--no citizen requirements--2 years college--graduate of professional school teaching a 4 year of 9 months each course.	Use of title--D.O., Dr. of Osteopathy, Osteopathic Physician--B.S. certificate.
Utah	Treatment of human ailments in accordance w/tenets of professional school	No age, character or citizen requirements--Osteopathic physician-graduate of professional school approved by A.O.A. teaching 4422 hours Osteopathic physician and surgeon same as above plus 1 year as surgical intern.	Use of title--must indicate osteopath w/use of degree--B.S. certificate.
Wisconsin	To prescribe or recommend any drugs or medical or surgical treatment or osteopathic manipulation for cure or relief of any bodily injury, infirmity or disease. Licensed by Medical Board.	No age or citizen requirement--high school graduate--good moral character--pre-med course--graduate of professional school with course equivalent to Univ. of Wisconsin Medical School--1 year internship.	Use of title--D.O., Dr. of Osteopathy--B.S. certificate.

PODIATRISTS

STATE	DEFINITION AND/OR SCOPE OF PRACTICE	LICENSE REQUIREMENTS	MISCELLANEOUS
Alabama	May diagnose and treat medically, surgically, mechanically, manipulate or treat electrically any ailment of feet. Surgery limited no deeper than the true skin.	No age, character or citizen requirement. Qualified by Medical Board of Examiners.	Use of titles--Foot Specialist, Foot Expert, Foot Correctionist, Podiatrist.
Arizona	Diagnosis and treat medically, surgically, mechanically, manipulation, or electrical treatment of ailments of foot and leg. No amputation, no anesthetics except local.	Age 21--good moral character--no citizen requirement--graduate of accredited school recognized by National Chiroprody Assn.	Use of titles--not defined Basic science certificate
Arkansas	Diagnose and medical, mechanical and surgical treatment of ailments of foot.	Age 21--good moral character--high school graduate--2 years college--graduate of recognized school teaching not less than 3 years of 8 months each.	Use of titles--D.S.C., Foot Expert, Foot Specialist--no citizen requirement.
California	Use diagnosis, medical, surgical, mechanical, manipulative, and electrical treatment of the human foot, includes the non-surgical treatment of the muscles and tendons of the leg governing the functions of the foot. No amputations. Use of local anesthetics.	Age 21--good moral character--graduate of approved professional school teaching not less than 4000 hours.	Use of titles--Podiatrist, Foot Specialist--no citizen requirements.
Delaware	The diagnosis and the medical, surgical, mechanical, manipulative and electrical treatment of all ailments of the human foot and leg. No amputation. Use of local anesthetics.	Age 21--good moral character--high school graduate--graduate of professional school--approved by Board teaching not less than 4 years of 8 months each (3980 hours)	Use of titles--Podiatrist, Chiropract, Foot Specialist, Foot Correctionist, Practopedist--no citizen requirement.
Florida	The diagnosis and medical, surgical, palliative and mechanical treatment of ailments of the human foot or legs. No amputations. Use local anesthetics.	Age 21--good moral character--U. S. citizen--graduate of Board approved school--teaching a 4 year course.	Use of titles--not defined

STATE	DEFINITION AND/OR SCOPE OF PRACTICE	LICENSURE REQUIREMENTS	MISCELLANEOUS
Iowa	Examine, diagnose or treat ailments of the human foot medically or surgically. No amputations. Use local anesthetics. No surgery above the ankle.	No age or moral character requirement--high school graduate--2 years college--graduate of approved professional school.	Use of title--Dr. w/podiatrist
Kansas	Diagnosis and treatment of all illnesses of human foot. No amputation of toes or feet. Use local anesthetic.	Age 21--good moral character--1 year college--professional school accredited by Board--no citizen requirement.	Use of titles--Registered Podiatrist--no title or abbreviation may be used unless accompanied by "Reg. Podiatrist" or "Practice Limited to Foot."
Louisiana	The mechanical, medical or surgical treatment of the minor ailments of the human foot, such as bunions, callouses, corns and ingrowing and abnormal nails. Use local anesthetics. Cannot correct deformities of foot by use of knife or by amputation.	Age 21--good moral character--graduate of recognized professional school with minimum requirement of 8 months.	Use of titles--not defined--no citizen requirement--examined by Medical Board.
Missouri	The local, medical, mechanical or surgical treatment of the ailments of the human foot, and massage in connection therewith. Use of local anesthetics. No amputation of toes or foot. No narcotics. No treatment of systemic disease.	Age 21--U. S. citizen--good moral character--high school graduate--1 year college--graduate of approved professional school.	Use of titles--Podiatrist, Chiropodist.
New Mexico	The diagnosis, medical, surgical, mechanical, manipulative and electrical treatment limited to ailments of foot and the non-medical and non-surgical treatment of the leg except the personal administration of anesthetics other than local.	Age 21--good moral character--U. S. citizen--high school graduate--1 year college--graduate of approved professional school (4000 hours)	Use of titles--D.S.C., M. Cp. Foot Specialist, Foot Treatment
Ohio	Treatment of ailments of hand or foot, non-systemic in character, and treatment of muscles and tendons of lower leg governing functions of the foot. Make molds and casts of feet. No operative procedures requiring use of general anesthetics. No x-ray or radium for treatment.	Age 21--good moral character--high school graduate--1 year of college--graduate of professional school approved by Board--no citizen requirement.	Use of title--D.D.S.

Podiatrists -- Page 3

STATE	DEFINITION AND/OR SCOPE OF PRACTICE	LICENSURE REQUIREMENTS	MISCELLANEOUS
Tennessee	Examines, diagnoses or treats medically, mechanically, or surgically the ailments of the human foot, massages in connection therewith. Cannot amputate toes or feet. Use local anesthetics.	Age 21--good moral character--1 year college--graduate of professional school teaching 4480 hours.	Use of title--not defined
Utah	Examine, diagnose, treat medically, mechanically or surgically, ailments of human foot or massages in connection therewith. No amputation of toes or feet. Use local anesthetics.	No age or citizen requirement--good moral character--high school graduate--graduate of professional school recognized by National Chiropractic Association which teaches at least 4160 hours in 4 years.	Use of title--D.S.C. and must indicate is Podiatrist.
Wisconsin	Diagnosis or mechanical or surgical treatment, or treatment by the local application of drugs, of the foot; but, does not include amputation or surgical operations on the feet for congenital or acquired deformities or conditions requiring the use of an anesthetic other than local. Can't treat above foot. Diagnosis and mechanical treatment above foot shall include tendons and muscles of lower leg involved in foot condition. No major or minor operations on foot involving vascular diseases or diabetes. No treatment of foot in osteomyelitis, malignancies or syphilis. No treatment by x-ray or radium.	Age 21--good moral character--1 year college--graduate of accredited professional school teaching not less than 4 years of 32 weeks--no citizen requirement.	Use of title--D.S.C., Dr. of Surgical Chiropractic, Registered Chiropractist.

OPTOMETRIST

STATE	DEFINITION AND/OR SCOPE OF PRACTICE	LICENSURE REQUIREMENT	MISCELLANEOUS
Alabama	Examination of human eye for ascertaining any departure from normal. Measure fractional powers and adopt mechanical means for aid thereof.	Age 21--good moral character--U. S. citizen--high school graduate--graduate of approved school which requires at least three years of study.	Use of title--O.D., Optometrist
Arizona	The examination and refraction of the eye by any means of correction except the use of drugs, medicine or surgery. Prescribe and fit glasses.	No age, citizen or character requirement--high school graduate of accredited optometric school--education qualification may be waived on proof of five year practice w/certification from an agency of another state or foreign country.	Use of title--O.D.
Arkansas	Use of any method except drugs, surgery or medicine. Prescribe and dispense lenses.	Age 21--good moral character--must be Arkansas resident 1 year prior to exam--graduate of class A optometric college accredited by A.O.A.	Use of title--O.D., Optometrist.
California	Measurement of the powers or range of human vision or determination of accommodation and refractive status of human eye or the scope of its function in general. Prescribe lenses, frames, optical devices, visual training, contact lenses.	Age 21--good moral character--no citizen requirement--60 semester college hours--graduate of accredited professional school teaching no less than 2800 hours	Use of title--Dr. w/Optomtrist, O.D. or Opt. D.
Delaware	Diagnosis and/or examination of human eye and appendages. Employ any subjective or objective means for purpose of refraction and visual, muscular or anatomical anomalies, or any ocular deficiency; prescribe and apply lenses, prisms, contact lenses; orthoptics or any physical, mechanical or psycho-visual therapy for correction, relief, or remedy of any insufficiencies or abnormalities of eyes or appendages. No drug or surgery.	Age 21--good moral character--no citizen requirement--high school graduate--1 year college--graduate of professional school approved by Board teaching course in 4 years (32 months)--6 months internship.	Use of titles--O.D. w/Optomtrist

Optometrist -- Page 2

STATE	DEFINITION AND/OR SCOPE OF PRACTICE	LICENSE REQUIREMENT	MISCELLANEOUS
Florida	Diagnosis of human eye and its appendages, employ objective and subjective methods of refraction, prescribe and employ lenses, prisms, frames, mountings, orthoptic exercises, light frequencies and any other means or method of correction, relief or remedies of insufficiencies of eye and appendages.	Age 18 years--citizen, good moral character--graduate of professional school which requires 4 years study (1000 hours each year)	Use of title--O.D. w/Optometrlist
Iowa	Any means other than medicine, drugs, or surgery to correct vision impairment and prescribe lenses.	High school graduate--graduate of accredited professional school approved by Board.	Use of title--Dr. w/Optometrlist or Opt.--P. G. for license renewal.
Kansas	Examination of human eye without use of drugs, medicine or surgery. Ascertain presence of defects or abnormal conditions correctible by use of lenses, prisms, or ocular exercises and their adaptation for the aid thereof.	Age 21--good moral character--no citizen requirement--high school graduate--graduate of professional school approved by Board with minimum of 4 years.	Use of title--not clearly defined.
Louisiana	Any means other than use of drugs, medicine, or surgery for measurement of the powers and testing the range of vision of human eyes; determine accommodative and refractive state, general scope of function, adaptation of frames and lenses.	No age--good moral character--U. S. citizen--high school graduate--graduate of professional school approved by Board.	Use of title--Doctor or Dr. w/Optometrlist, O.D., Opt. D., D.O.S.
Missouri	Examination of human eye without the use of drugs, medicine or surgery. Ascertain presence of defects or abnormalities, use objective or subjective mechanical means to determine power of vision, use ocular exercises. Prescribe lenses or prisms.	Age 21--good moral character--no citizen requirements--high school graduate--graduate of approved professional school.	Use of title--not defined.
New Mexico	Any subjective or objective means or methods, except drugs or surgery, to determine refractive condition of eyes or any muscular or visual anomalies. Employ adapt or prescribe lenses, prisms or optical appliances.	Age 21--citizen--good moral character--high school graduate--graduate of Board approved professional school (5000 hours- 5 years of 8 months each)	Use of title--not defined required 2 day P.G. for license renewal.

Optometrist -- Page 3

STATE	DEFINITION AND/OR SCOPE OF PRACTICE	LICENSE REQUIREMENT	MISCELLANEOUS
Ohio	Application of optical principles, through technical methods and devices in the examination of the human eye for purpose of ascertaining departures from normal, measure functional powers and adapt optical accessories for aid thereof.	Age 21--good moral character--no citizen requirement--2 years college--graduate of Board approved professional school.	Use of title--not defined.
Tennessee	Use of objective or objective methods to ascertain defects of vision or muscular anomalies or abnormal conditions of eye. Prescribe lenses and orthoptic training.	Age 21--good moral character--no citizen requirement--high school graduate--graduate of professional school requiring 4000 hours in 4 years of 8 months each.	Use of title--O.D. accompanied by Optometrist.
Utah	Examination without use of drugs, medicine or surgery to ascertain defects or abnormal conditions which can be corrected by use of lenses, contact lenses, prisms or ocular exercises.	Age 21--good moral character--no citizen requirement--high school graduate--graduate of professional school approved by Board.	Use of title--not defined.
Wisconsin	Any means other than drugs to determine visual efficiency of eye. Measurement of powers or defects of vision. Furnish, using or employing any means or device designed to aid in selection or fitting of lenses, prisms and mechanical therapy to aid the vision of any person.	Age 21--good moral character--no citizen requirement--graduate of Board approved professional school.	Use of title--can't use term Dr.

DENTISTS

STATE	DEFINITION AND/OR SCOPE OF PRACTICE	LICENSE REQUIREMENT	MISCELLANEOUS
Alabama	To treat, operate, diagnose lesions of human teeth, gums, jaws, oral cavities by any means.	Age 21--good moral character--graduate of Board approved dental school.	Use titles--D.D.S., D.M.D.--advertising restrictions--no citizen requirement.
Arkansas	To treat lesions of teeth, gums, oral cavity by any means or method.	Age 21--good moral character--graduate of reputable dental school.	Use titles--D.D.S., D.M.D.--no citizen requirement.
California	To perform, operate or use diagnosis of any kind; to treat diseases or lesions of human teeth, alveolar processes, gums, jaws or associated structures or correct malposed positions thereof. Construct, alter repair, or sell any bridge, crown, denture or other prosthetic appliance or orthodontic appliance.	Age 21--good moral character--graduate of an approved, reputable dental school.	Use titles D.D.S., D.D.Sc., D.M.D.--no citizen requirement.
Delaware	Diagnose or treat disease or lesions of human teeth jaws, or oral tissues mechanically, medicinally, surgically, or by use of radiograms, x-rays or fluoroscopic methods, correct malpositions and take impressions for replacement of teeth.	Age 21--citizen--good moral character--2 years college--graduate of approved dental school--1 year internship	Use titles D.D.S., D.M.D.--Dentist, Dental Surgeon.
Florida	Prescribe drugs, medicine, surgical operations, administer local or general anesthetics, use appliances, use any dental operation, or oral surgery or dental service of any kind.	Age 21--good moral character--U. S. citizen--graduate of A.D.A. approved dental school.	Use titles--D.D.S., D.M.D., along with word Dentist.
Iowa	Any method, appliance or medicine to treat any disorder, lesion, injury, deformity or defect of oral cavity, teeth, gums, or maxillary bones of the human.	Graduate of Board approved dental college.	Use titles--Dr. w/D.D.S. or Dentist or Dental Surgeon.

Dentists -- Page 2

STATE	DEFINITION AND/OR SCOPE OF PRACTICE	LICENSE REQUIREMENT	MISCELLANEOUS
Kansas	Any means or method of dental operation, oral surgery, impressions of teeth, jaw, replace teeth, supply artificial teeth, dentures, bridges, fill cavity, correct malformations; treat, diagnose disease, pain deformity, deficiency, injury or physical condition of teeth or jaws.	Age 21--good moral character-- U. S. citizen--graduate of A.D.A. approved professional school-- additional requirements needed to specialize.	Use of titles--Doctor or Dr. along w/D.D.S., D.M.D., B.D.S., M.D.S., or L.D.S.
Louisiana	Diagnose, treat, remove stains and concretions of teeth; operate, prescribe for any disease, pain injury, deficiency, deformity, or physical condition of teeth, alveolar process, gums or jaws or associated parts; take impression of teeth, replace teeth, make and repair plates, use anesthetics, drugs or medicines.	No age or moral character requirements--U.S. citizen--graduate of A.D.A. approved professional school.	Use of titles--Doctor w/B.D.S., or M.D.S., D.D.S., D.M.D., L.D.S.
Missouri	Diagnose, examine and contract for treatment of any disease, disorder, lesions of oral cavity, teeth, gums, maxillary bones. Extract teeth, repair or fill cavities, correct malpositions of teeth or jaws, supply artificial teeth, plates, dentures, administer anesthetics or any other means as taught in recognized dental colleges.	Age 21--good moral character-- graduate of Board approved dental school--special Board requirements for specialists-- no citizen requirement.	Use of titles--D.D.S., Dentist and Dental Surgeon.
New Mexico	Diagnose, treat, perform operations, administer anesthetics in connection w/any condition, disease, lesion of teeth, gums, jaws or oral cavities or adjacent tissues; take impressions, correct malposition, treat fractures, remove calcareous deposits replace missing anatomy, make appliances.	Age 21--good moral character-- U. S. citizen--graduate of Board approved dental school.	Use of titles--not defined.

Dentists -- Page 3

STATE	DEFINITION AND/OR SCOPE OF PRACTICE	LICENSURE REQUIREMENT	MISCELLANEOUS
Ohio	Perform dental operations, diagnose or treat disease or lesions of human teeth or jaws, correct malpositions thereof, take impressions, repair and make dentures.	Age 21--good moral character--graduate of Board approved reputable dental school.	Use of titles--D.D.S., Dentist, Dental Surgeon--no citizen requirement.
Tennessee	Any practice as included in curriculum of recognized dental colleges.	Age 21--good moral character--graduate of approved dental college--need special license for specialty.	Use of title--not defined--no citizen requirement.
Utah	Treat, diagnose, operate or prescribe for any disease, pain, deficiency of the human teeth, gums, jaws, supply artificial teeth.	Age 21--good moral character--high school graduate--graduate from Board approved dental college.	Use of title--D.D.S., D.M.D., Dentist, Dental Surgeon, Prosthetist--no citizen requirement.
Wisconsin	Perform dental operations of any kind and practice dentistry by any means.	No age, moral or citizen requirement--2 years college--graduate of Board approved dental school.	Use of title--Doctor, D.D.S., Dr. of Dental Surgery.

MEDICINE

STATE	DEFINITION AND/OR SCOPE OF PRACTICE	LICENSURE REQUIREMENT	MISCELLANEOUS
Alabama	Treating of diseases of human beings by any system whatsoever	2 years college--MD degree from Board approved medical college--internship--not specified.	Special examination and certification required for major surgery no age requirement--basic science certificate
Arizona	The treatment and diagnosis of human diseases	Proof of citizenship and good moral character--graduate of AMA approved college--1 year internship in approved hospital	No age requirement--basic science certificate
Arkansas	The treatment and diagnosis of any human disease by any method.	Must be citizen, good moral character--21 years old--graduate of AMA approved college	May use M.D. or M. B. title--physician and surgeon--basic science certificate.
California	To engage in or practice any system or mode for treating sick or afflicted; to use drugs, medical preparations on humans and to sever or penetrate the human tissue and to use any and all methods in treatment of diseases, injuries, deformities or other physical or mental conditions.	3 years college--graduate of Board approved medical college--1 year internship.	May use M.D. - physician and surgeon--no age or citizen requirement.
Delaware	To investigate, diagnose, and give surgical assistance to, or to suggest, recommend, prescribe or direct for the use of any person any drug, medicine, appliance, or other agency for the cure, relief or palliation of any ailment or disease of mind or body.	21 years of age--good moral character--U. S. Citizen--high school graduate--2 years college--graduate of Board approved medical college--1 year internship	Use term Dr., Doctor, M.D., Healer
Florida	To diagnose, treat, operate or prescribe for any human disease, pain, injury, deformity or physical condition.	Age 21--good moral character--graduate of professional school approved by Board--1 year internship or 5 years experience in lieu thereof.	Basic science certificate.

Medicine -- Page 2

STATE	DEFINITION AND/OR SCOPE OF PRACTICE	LICENSE REQUIREMENT	MISCELLANEOUS
Iowa	To prescribe and furnish medicine for human ailments or treat the same by surgery.	No age requirement--U. S. citizen graduate of approved medical college--1 year internship at approved hospital.	Basic science certificate.
Kansas	Prescribe, recommend or furnish medicine or drugs, perform any surgical operation of whatever nature by the use of any surgical instrument, procedure, equipment, or mechanical device for the diagnosis, cure or relief of any wounds, fracture, bodily injury infirmity, disease or illness of human beings.	No age requirement--no citizen requirement--high school graduate--graduate of approved medical school--approved internship.	Basic science certificate--use terms physician, surgeon, physician and surgeon, M. D.
Louisiana	Any means or agency to diagnose, treat, cure or relieve any bodily condition.	Age 21--good moral character--U. S. citizen--graduate of any school which teaches medicine or any healing art.	No definite use of titles or term.
Missouri	To practice medicine or surgery in any of its departments; to cure and treat the sick and others afflicted with bodily or mental infirmities, to engage in midwifery.	No age requirement--U. S. citizen--good moral character--high school graduate plus 60 semester hours in college--graduate of AMA approved college with course of 4 years (32 weeks) of which last 2 years must be spent in operative or hospital work.	Use titles Dr., Doctor, M. D., Physician.
New Mexico	To investigate or diagnose, suggest, recommend, treat prescribe or direct any disease, physical or mental ailment by use of any drugs, medicine, appliance or other agency for cure and relief of any conditions.	U. S. citizen--good moral character--graduate of professional school approved by board.	Use of titles not defined--no age requirement--basic science certificate.

Medicine -- Page 3

STATE	DEFINITION AND/OR SCOPE OF PRACTICE	LICENSE REQUIREMENT	MISCELLANEOUS
Ohio	The application and use of medicines and drugs for purpose of curing, mitigating, or alleviating bodily diseases. The practice of surgery is limited to manual operations usually performed by surgical instruments or appliances.	Age 21--good moral character--high school graduate--2 years college--graduate of approved professional school.	No citizen requirement--use titles Dr., M.D., M. B.
Tennessee	To treat, operate and prescribe for any physical deformity or injury.	No age, moral character or citizen requirement--graduate of approved professional school.	Basic science certificate--use title M.D., Physician and Surgeon.
Utah	The treatment of human ailments in accordance with the tenets of the professional school.	Age 21--good moral character--1 year college--graduate of professional school (4 years)--recognized by Department of Registration.	Basic science certificate--no citizen requirement.
Wisconsin	To prescribe or recommend any drugs or other medical or surgical treatment for the cure or relief of any bodily injury, infirmity or disease.	High school graduate--good moral character--graduate of professional school with curriculum equal to University of Wisconsin Medical School--pre-med course and 1 year internship.	Basic science certificate--use title M.D., Dr. of Medicine, no citizen or age requirement.

P R E F A C E

1. The Health, Education and Welfare Secretary's Report on chiropractic
(a) is biased and was prepared by a prejudiced group unable to provide objective advice; and it
(b) fails to provide Congress with the principal information it requested—the need for and costs of chiropractic in Medicare.
2. There is a need for chiropractic services for Medicare beneficiaries.
3. Such chiropractic services can be provided Medicare beneficiaries **only** by doctors of chiropractic licensed by the respective states to provide such services.
4. Medicare should be amended to allow Medicare beneficiaries **freedom of choice** to select the services of doctors of chiropractic.
5. Such chiropractic services would not significantly raise Medicare costs.

WHY A HEALTH, EDUCATION AND WELFARE REPORT?

In enacting the Social Security Amendments of 1967, P.L. 90-248, the Congress decided that it needed more information on "the need for covering" independent healing professions not included in medicare, such as chiropractic, optometry, and occupational therapy, "and the cost" of such additional services.

Therefore, it enacted Section 141 directing the Secretary of Health, Education and Welfare to make such a "needs" and "cost" study. The study was specifically committed to the Health, Education and Welfare Secretary after a conference committee rejected a proposal that it be made by the medically-oriented United States Public Health Service.

The report, "Independent Practitioners Under Medicare," dated December 28, 1968, covers nine professions including chiropractic.

The present medicare law, Title XVIII of the Social Security Act, so defines the term "physician" that it does not include a doctor of chiropractic. In the 89th and 90th sessions of Congress in 1965 and 1967, the United States Senate overwhelmingly voted to include chiropractic. To date in the 91st Congress, there are thirty-four bills for this same purpose.

THE REPORT'S FAILURE TO ADVISE CONGRESS

Insofar as chiropractic is concerned, the Health, Education and Welfare Report completely fails to advise the Congress as to "needs" and "costs." It utterly ignores the two principal items requested by the Congress: the medicare beneficiary's need for chiropractic, and the cost of chiropractic services to the government and to the individual receiving service.

Instead, the report devotes its principal attention to a philosophic discussion of the theories of various recognized schools of the health arts in the form of a debate between medicine vs. chiropractic health care. The healing arts have long been a battleground among different schools or approaches to health, such as allopathic medicine, homeopathy, osteopathy, and chiropractic. The Health, Education and Welfare Report is basically a self-defense by the dominant allopathic school of healing. None of this philosophical or theoretical controversy has the slightest relevance to the critical issues which Congress correctly pinpointed:

- (1) Do medicare beneficiaries need chiropractic services?
- (2) What will such chiropractic services cost the medicare program?

Congress enacted medicare as a benefit to patients, not as a boon to doctors. Congress asked the Health, Education and Welfare Department for advice about the need of medicare beneficiaries for chiropractic care; but the department ignored this request. The Health, Education and Welfare Secretary's report is couched in terms of philosophical theories of competing schools of medicine and health care, without any regard to Congress's questions or to the efficacy of chiropractic care. Medicare should be patient-oriented, not profession-oriented.

Congress asked Health, Education and Welfare for information ("need" and "cost") on the basis of which a Congressional decision could be made as to whether chiropractic was to be included in medicare. In failing to comply with Congressional request, especially as to "need" and "cost", and in substituting its judgment for that of Congress as to chiropractic, the Health, Education and Welfare Report is presumptuous as to Congress's constitutional prerogatives.

The Health, Education and Welfare Secretary's Report (prepared by consultation with the Ad Hoc Consultant Group) not only failed to supply Congress with the specific information requested, but exceeded its authority by ignoring the specific limitations placed upon the study.

The Secretary of the Health, Education and Welfare was directed to make a study of services "of additional types of licensed practitioners performing health services in independent practice." However, Health, Education and Welfare (through the device of the Ad Hoc Consultant Group)

made a study of health services which are not licensed, such as occupational therapists, social workers, speech pathologists, audiologists, and corrective therapists. Although these may be valuable services, Congress did not authorize such a study.

Thus, the Health Education and Welfare Report fails to advise Congress on the two issues specified in law and introduces one not authorized by law. Consequently, Health, Education and Welfare's presumptuous report should be shelved as irrelevant and unresponsive to Congressional intent.

A "FIXED" REPORT

Directly contrary to Congressional intent, the Health Education and Welfare Report was prepared within the United States Public Health Service, with the result Congress had specifically intended to circumvent: A biased report which is wholly unreliable.

The principal device for the preparation of the Health Education and Welfare Report was the appointment of two committees of nongovernmental persons. Both such groups had an overwhelming built-in professional and institutional bias against chiropractic which made it impossible for them to provide objective and unbiased advice. The groups were constituted as follows:

A. Ad Hoc Consultant Group

This group was composed of twenty-two persons. Of this number, at least twelve were professionally or institutionally prejudiced against chiropractic in view of the position of their professions or organizations:¹

7 were Medical Doctors	1 was a medical hospital administrator
1 was a Doctor of Osteopathy	1 was a health college dean
1 was a Doctor of Dental Science	1 was a nursing service official

The group was responsible to Dr. John W. Cashman, Assistant Surgeon General, United States Public Health Service, who admitted privately to a representative of the chiropractic profession that he was opposed to chiropractic before the study began.

During hearings and formation of the study, the Public Health Service rejected repeated requests for chiropractic observers at the meetings of the Ad Hoc Consultant Group.

B. Expert Review Panel

A specialized group specifically on chiropractic was appointed. Composed of eight members, at least six of the group were professionally or institutionally prejudiced against chiropractic:²

5 were Medical Doctors	1 was a professor of sociology
1 was a medical school professor (anatomy)	1 was a foundation executive

(with no representation from the chiropractic profession)

With such a prejudiced set of committees, composed of people with pre-determined biases against chiropractic, the only result that would be expected was an unfavorable report. The elemental standards of decency and fairness were wholly and deliberately rejected. Instead, a "fixed jury" was chosen. The American people interested in the use of chiropractic services were denied the basic requirements of due process, to wit: a fair and unbiased study. Consequently, as a "fixed" report, the Health, Education and Welfare Report is totally unworthy of consideration.

FALSE ISSUES

Instead of reporting on the true issues specified by the Congress in law, the Health, Education and Welfare Report deals with a group of erroneous issues. It ignores or misstates the facts. Some of these false issues and the actual facts raised by the report include:

I. FALSE ISSUE NO. 1—CHIROPRACTIC EDUCATION

Claim: Chiropractic education is not acceptable.

Fact: Chiropractic education is a highly sophisticated, scientific and professional course of instruction requiring four academic years of resident instruction in colleges of chiropractic.

1. Curriculum*

Table I below shows that chiropractic colleges provide more hours of instruction than medical schools in the following subjects:³

- | | | |
|---------------|-------------------|------------------|
| 1. anatomy | 3. radiology | 5. nutrition |
| 2. physiology | 4. rehabilitation | 6. public health |

Understandably, medical schools give full instruction in surgery and pharmacology while chiropractic colleges stress chiropractic principles and practice.

Table I compares the number of hours devoted to subjects in medical schools and chiropractic colleges.

TABLE I⁴—CURRICULAR COMPARISON
Based on College Bulletins for the 1967-1968 Year

	No. Colleges Reporting Hrs.		Average Length of Course in Hrs.		No. Colleges Not Listing the Subject	
	Chiro.	Med.	Chiro.	Med.	Chiro.	Med.
Anatomy	11	55	779	554		
Biochemistry	11	56	154	228		
Physiology	11	54	323	265		
Microbiology	11	51	157	214		
Pathology	11	55	350	385		
Public Health	11	46	97	88		9
Obstetrics and Gynecology	11	45	106	399		
Pediatrics	11	48	46	407		
Psychiatry	11	49	125	336		
Radiology	11	41	217	52		14
Pharmacology		53		185		
Toxicology	9		32		2	
Physical Medicine		18		31		50
Rehabilitation &/or Physiotherapy	5		105		6	
Chiropractic	11		1,874			
Medicine		48		1,386		
Surgery		45		744		
First Aid	10		38		1	
Nutrition	10	0	54	0	1	74
Electives	10	29	184	428	1	45
Arts and Science		1		1,292	11	75

Note No. 1: Eighty-five medical colleges contacted. Seven failed to respond, thirty-five college catalogues contained incomplete subject hours. All eleven United States chiropractic colleges are included in the survey.

Note No. 2: The subjects listed as "Chiropractic" and "Medicine" cover a section of diagnosis and also the treatment procedures of the two respective professions.

*Based on a study of the catalogues of medical and chiropractic colleges.

2. Students

Table II compares entrance requirements for medical schools and chiropractic colleges.

TABLE II⁵
Educational Entrance Requirements*
Based on College Bulletins for the 1967-1968 Year

	Chiropractic Colleges	Medical Schools
Bachelors Degree (4 Years)	0.0	9.4
Three years of college	0.0	83.5
Two years of college	72.7	0.0
One quarter year	9.1	0.0
High School (no college units)	18.2	1.2
Not reporting	<u>0.0</u>	<u>5.9</u>
	100 per cent	100 per cent

Both medical schools and chiropractic colleges accept "C" students. The following quotation is from the **Journal of the American Medical Association**:

"Many persons, including some doctors, seem to believe that medical schools predominantly accept 'A' students and that the 'C' student has no chance of acceptance."

*"Through the years for which records are available, this is simply not true. Nor is there any evidence that schools generally have raised or lowered their requirements."*⁶

3. Chiropractic Degree

The validity of a Doctor of Chiropractic degree is attested to by the United States Office of Education in its most recent edition of the publication **Academic Degrees**, p. 169.

II. FALSE ISSUE NO. 2—CHIROPRACTIC "PHILOSOPHY"

Claim: That certain quotations from early writings of the chiropractic profession represent modern day chiropractic.

Fact: The Health, Education and Welfare Report cites quotations out of context and confuses hypotheses for chiropractic clinical findings, thus deceiving the Congress and the American people.

When the doctor of chiropractic clinically observes a condition in a patient, he seeks to find out "Why?", just as is done in physics, chemistry, and medicine. After such clinical observations are made, an attempt is made to explain the condition by a hypothesis. Such hypotheses are found in chiropractic literature under the heading of "Chiropractic Principles or Philosophy;" but they are chiropractic hypotheses.

The probability or non-probability of the hypothesis does not alter the chiropractic clinical facts, for the hypothesis is simply an interim attempt to explain the etiology of the clinical fact.

⁵This report is based on eighty-five medical schools and all eleven chiropractic colleges.

Health, Education and Welfare's Report attacks chiropractic's concern with subluxations (a chiropractic clinical fact), but itself admits that specialists in physical medicine and rehabilitation agree that subluxations exist.

Chiropractic treats the ailment disclosed by the clinical facts, not by hypothesis. The patient's needs are met by the clinical efficacy of chiropractic, not by conflicting arguments on hypotheses. Health, Education and Welfare dealt with hypotheses; Congress wanted to know about needs and costs and whether chiropractic is a valid health service for the elderly.

III. FALSE ISSUE NO. 3—DIAGNOSIS

Claim: Doctors of chiropractic are unable to diagnose patients and are therefore not able to know when to refer patients for treatment by other health practitioners.

Fact: Every chiropractic college teaches physical examination and diagnostic procedures and examines (or tests) in physical, clinical, laboratory, and differential diagnosis, in addition to chiropractic analysis. Before receiving a license to practice chiropractic, candidates are examined in diagnosis either by official State Boards or by the National Board of Chiropractic Examiners or both.

The chiropractic curriculum is oriented toward patient management, that is, to the recognition of the measures best suited to the restoration and maintenance of the patient's good health (whether such measures are applied by a doctor of chiropractic or by another health professional on referral).

There are several objective indications of the substantiality of these aspects of the chiropractic curriculum, e.g., the amount of time spent in classwork and the proportion of contents of the required textbooks that deal with diagnosis.

Classwork

The subjects taught at chiropractic colleges in the area of diagnosis include: physical, clinical, laboratory and differential diagnosis; roentgenology; pediatrics; geriatrics; dermatology; and communicable diseases, among others.

There are two categories of such classwork—those formally designated as diagnosis and those actually involving diagnosis as a substantial part of a course on a specific subject. In the first group, Table I on page 7 lists an item, "Chiropractic." This includes 564 hours of formal classes in diagnosis covering the subjects of physical, clinical, laboratory, and differential diagnosis; geriatrics; dermatology; and clinical neurology. It also includes over seven hundred hours of practical training in this discipline during the required clinical clerkship* and externship** programs.

But this is by no means the sum total of the relevant portion of the college curriculum, since the specific subject matter courses, in addition, devote substantial class time directly to physical, clinical, laboratory, and differential diagnosis.

The faculty of a chiropractic college surveyed the percentage of that college's courses during the current academic year which relate to diagnosis. These are the findings of the survey:⁷

(a) Sixty-two courses were surveyed.

(b) These sixty-two courses represent virtually the entire curriculum of the college which involves a total of over 4485 hours of course work required for a chiropractic degree.

*Clinical clerkship. An assigned tenure in the various departments of a college associated out-patient clinic.

**Externship. Homologous to the term internship in medical schools, but used to differentiate the fact that this service is done in college affiliated out-patient clinics, not hospitals with in-patient services.

(c) The average time devoted in class to differential diagnosis is estimated to be 43 per cent of the total course hours of the sixty-two courses.

Another chiropractic college estimated the proportion of class time in seven specific major subjects dedicated to diagnosis was:⁸

Roentgenology	85%	Toxicology	60%
Psychiatry	90%	Parasitology	60%
Pediatrics	80%	Bacteriology	60%
Gynecology	80%		

Textbooks

The standard textbooks used for the basic and diagnostic sciences in chiropractic colleges are essentially identical with those used in medicine and osteopathy.⁹

In one chiropractic college, it was estimated that well over 65 per cent of the required textbooks deal, in part or in whole, with the study of diagnosis. The faculty of this chiropractic college estimated that the below-indicated percentage of the contents of their required textbooks were devoted to diagnosis:¹⁰

Roentgenology	85%	Obstetrics	50%
Orthopedics	80%	Gynecology	50%
Pediatrics	80%		

In a substantial proportion of other texts, some 30 per cent to 40 per cent of the books were devoted to material on diagnosis.

Thus, an objective evaluation of chiropractic education discloses that doctors of chiropractic are well educated in this discipline to recognize the need for chiropractic care and for referral of those patients where non-chiropractic methods would be more advantageous or necessary.

Table III shows the findings of a survey by Batten and Associates:

TABLE III¹¹
Referrals by Doctor of Chiropractic

Question 74: Doctors of chiropractic who refer patients to other practitioners for treatment:		Question 74A: Patients were referred to:	
	Percentage		Percentage
Yes, refer patients	90.3	Medical Doctors	86.5
No, do not refer patients	6.5	Doctors of Chiropractic	67.1
No answer	3.1	Doctors of Osteopathy	26.0
	99.9*	Other	11.5
		No Answer	0.0
			191.1**

*The table is taken directly from the Batten and Associates report. The 99.9% is so because they dropped the second and third fraction of the individual percentages because they were below (.05) five hundredths of a per cent—a normal and acceptable procedure.

**The 191.1% is explained by the fact that the total exceeds 100% because of multiple answers, also an acceptable procedure. It means that many doctors referred patients to more than one classification of practitioners, i.e., D.C.'s and M.D.'s, or M.D.'s, D.O.'s and D.C.'s etc.

IV. FALSE ISSUE NO. 4—CAUSE OF DISEASE

Claim: Chiropractic regards subluxations as the sole cause of disease.

Fact: This is incorrect. Chiropractic care is primarily concerned with the well being and recovery of the patient and with the restoration and maintenance of good health. Present day chiropractic does not hold that the subluxation is the only cause of disease. Whatever may have been said in chiropractic literature years ago, today's chiropractic education and practice recognizes multiple causes of, and multiple methods of treatment for, disease.

The doctor of chiropractic must first evaluate the needs of the patient before administering any type of care. If he should determine that the case is within his scope, he proceeds to provide appropriate care. But if he determines that the patient requires another type of care, he refers the patient to that method which he believes is most advantageous.

As indicated in Table III, over 90 per cent of practicing doctors of chiropractic report that they refer patients to other practitioners, and that almost 90 per cent of such referrals are to medical doctors.

The Health, Education and Welfare Report reflects the fact that patients with a variety of pathologies consult the doctor of chiropractic but fails to indicate that the majority of the patients treated under chiropractic are suffering from neuro-musculo-skeletal problems.

The Health, Education and Welfare Report also fails to recognize what was shown above, that the education of the doctor of chiropractic enables him diagnostically to recognize the need for chiropractic services and for referral of those patients where non-chiropractic methods would be more advantageous or necessary.

TRUE ISSUES

The Health, Education and Welfare Secretary's Report ignored the true and basic issues on which Congress sought information and advice and on which public policy decisions by Congress more properly rest. There are four such true issues:

I. TRUE ISSUE NO. 1—NEED FOR CHIROPRACTIC

Issue: Is there a need?

Fact: Yes.

The need for chiropractic services is best ascertained by the American people's demand for such services. The following clearly proves the need for chiropractic services as recognized both in law and in practice:

A. Government Programs

1. Federal Government

- a. **Medicaid.** Congress itself authorized chiropractic services under Medicaid, Title XIX of the Social Security Act. At this time, seventeen states now provide chiropractic care under Medicaid.
- b. **Federal Civil Service.** All Federal departments and agencies accept statements from doctors of chiropractic for sick leave of any Federal employee.
- c. **Income Taxes.** The Federal government permits medical deductions for chiropractic health services under Federal income tax law.

- d. **Immigration Law.** The Federal government recognizes chiropractic colleges as a basis for admitting aliens into the United States with special status as students.¹²
- e. **Public Health Service Reports.** The United States Public Health Service classifies chiropractors among "medical specialists and practitioners" in a 1966 study including pediatricians, obstetricians, and ophthalmologists, among others. The Public Health Service's Health Manpower Source Book includes doctors of chiropractic along with physicians, surgeons, and dentists.

2. State Governments

- a. **Licensure.** Chiropractic is an officially recognized health profession in forty-eight states, the District of Columbia, and in Puerto Rico. Each of these states or jurisdictions has specific laws defining the practice of chiropractic, prescribing requirements for licensure, and authorizing chiropractic services and care.
- b. **Workmen's Compensation.** Claims for chiropractic care are paid by Workmen's Compensation in forty-eight states and the District of Columbia.

B. Non-Government Programs

1. Commercial Insurance

Many hundreds of commercial insurance companies (including most of the private carriers used to administer medicare) include chiropractic in their health and accident policies.

2. Health and Welfare Funds of Labor Unions

Many health and welfare programs of labor unions include chiropractic care. For example, in one state alone (California) more than 108 such labor health and welfare programs include chiropractic services.¹³

As such workers retire, they find themselves unable to obtain under medicare, the chiropractic services from which they benefited under private health and welfare programs.

3. Public Utilization of Chiropractic

The most recent data available from the United States Public Health Service indicates that in 1963-1965:

- a. 4,250,000 persons in the United States, or 2.3 per cent of the civilian non-institutional population,¹⁴ consulted a doctor of chiropractic.
- b. Of the pre-medicare age (45-64), 4.2 per cent of the population of the United States received chiropractic services.* The percentage of elderly patients using chiropractic services has increased since the period covered in the above quoted report. For the period of July, August, and September, 1968, an analysis of the medicaid program in California indicates that over 5.5 per cent of the over-sixty-five beneficiaries were availing themselves of the services of the chiropractic profession.**

The need of people who are actually in the medicare program is especially relevant. The aged are more prone to all diseases. A recent publication reports that for 1963-1965 one-third of conditions causing activity limitations to persons sixty-five years and older were due to musculo-skeletal impairment.***

*National Center for Health Statistics, Series 10, No. 28, p. 37.

**Higley, H.G., "Patients Past 65 Under Medical," A Projection of Figures supplied by Blue Shield, 1968. Unpublished.

***National Center for Health Statistics, Series No. 10, No. 32, p. 55.

Among the general practitioners of the healing arts, doctors of chiropractic are better qualified in the detection and correction of such impairments. This is due to the quality and quantity of the education they receive which enables them diagnostically to recognize the need for chiropractic care and to refer those patients where non-chiropractic methods would be more effective or necessary.

C. Rural and Farm Areas

The crisis in health manpower is a well-documented fact in American life. Farm and rural families are especially in need of health services, and chiropractic is geographically available to provide such services:

1. A major study of the United States Public Health Service indicates statistically a greater orientation of doctors of chiropractic to rural and non-urban America than is true of other health professions.*
2. The President's National Advisory Commission on Rural Poverty reported that only 12 per cent of M.D.'s are located in rural areas.**
3. A recent chiropractic estimate is that over 60 per cent of doctors of chiropractic in 1968 were located in communities having a population of 50,000 or less.

Thus, chiropractic benefits under medicare would be especially important in meeting the needs of rural and farm people.

II. TRUE ISSUE NO. 2—COST OF CHIROPRACTIC IN MEDICARE

Issue: Will chiropractic benefits add costs to the medicare program?

Fact: No.

Title XVIII (medicare) of the Social Security Act includes two parts: Part A, on Hospitalization; and Part B, on Supplementary Medicare Insurance Benefits (or out-patient care). Inclusion of chiropractic will save the medicare costs in Part A for patients treated by doctors of chiropractic and will not add to costs in Part B in any significant way, if at all. The situation is as follows:

1. Part A—Hospitalization (under medicare)

Chiropractic care does not require that patients be hospitalized. This is so even where treatment of the same ailment by a medical doctor may result in expensive hospitalization.

Therefore, the entire Part A cost is saved for all chiropractic patients under medicare.

The extensive scope of the resultant saving to the Federal government under Part A can be seen from the fact that during the first year of medicare's operation, over 78 per cent of its cost went toward hospital payments under Part A.

Of a total payment by medicare of \$3.2 billion, in this first year

- (a) \$2.5 billion was for Part A, and
- (b) \$700 million was for Part B.***

ALL OF THESE HOSPITALIZATION COSTS WOULD BE SAVED FOR CHIROPRACTIC PATIENTS UNDER MEDICARE.

*Public Health Service, National Center for Health Statistics, Series 10, No. 28, p. 38.

**People Left Behind, September, 1967, p. 63.

***Source: Mrs. Dorothy P. Rice, Chief, Social Security Administration's Health Insurance Research Branch, October 24, 1967, paper before American Public Health Association.

2. Part B—Supplementary Medical Insurance Benefits

Chiropractic inclusion in medicare will not result in any substantial cost increase under Part B for

- (a) Fees for out-patient treatment.
- (b) Drugs and biologicals.

a. Fees for (Out-patient) Treatment:

The total out-patient treatment costs for comparable ailments is less (or at least no higher) for chiropractic doctors than for medical doctors.

Chiropractic is an alternate service to what is already authorized under medicare, to the extent of applicable state law. Therefore, if a patient under medicare exercises his freedom of choice to go to a chiropractic doctor instead of a medical or osteopathic doctor, he will normally not go to both for treatment. The result is a saving of treatment costs to medicare, or at the very least, no additional costs for treatment by chiropractors. Evidence for this fact comes from four sources:

(1) Insurance Companies

Insurance companies which write policies including chiropractic benefits have stated in writing that chiropractic benefits do not increase their premiums.

Obviously, if chiropractic benefits increased costs, the premiums would have to rise.

Commercial insurance carriers find that chiropractic does not increase their costs, so it is reasonable to assume that chiropractic benefits will not increase the costs of Part B of medicare.

(2) Workmen's Compensation

Forty-eight states and the District of Columbia provide chiropractic benefits under their workmen's compensation programs. Workmen's Compensation Commissions or Boards have stated that chiropractic benefits do not increase their costs.

Evidence to this effect is included in the data on the Florida study noted below to the effect that treatment costs for substantially identical cases were 27.5 per cent more for cases handled by medical doctors than for cases handled by chiropractic doctors.¹⁵

(3) Government-operated Health Services

The Province of British Columbia, Canada, operates a British Columbia Government Employees' Medical Service, which provides chiropractic benefits as well as other healing art services.

Official data show the following comparative costs for the year 1966:

OFFICE VISITS	COST
By medical doctor	\$4.38
By chiropractic doctor	3.81

Thus, chiropractic services were rendered at a 13-per cent saving compared to services by medical doctors.

Other government programs in California,¹⁶ Iowa,¹⁷ and Oregon¹⁸ show similar savings in the cost of chiropractic care.

(4) Experience of Employers

A substantial number of American employers, businessmen, and other leaders have stated that chiropractic does not cause any increased cost, and, in fact, may reduce costs when used by their employees or associates.

3. Drugs and Biologicals

The medicare program allows payment for drugs and biologicals (which cannot be self-administered) which are furnished as an incident to a physician's service under certain circumstances.

Chiropractic is a drugless health service, even where treatment of similar ailments by medical doctors may involve extensive medication. Consequently, the entire cost of drugs and biologicals is saved under Part B for chiropractic patients.

The conclusion, based on the facts, is that chiropractic's inclusion in medicare raises no adverse cost problems.

III. TRUE ISSUE NO. 3—EFFECTIVENESS OF CHIROPRACTIC SERVICES

Issue: Are chiropractic services effective in helping sick people?

Fact: Yes.

The efficacy of chiropractic is a factual and empiric determination, not a theoretical consideration. Chiropractic must be measured by the result obtained in various types of clinical situations. The following are a few examples of evidence in practical instances:

1. Workmen's Compensation Cases

In 1960, a study was made of the workmen's compensation records of the Florida Industrial Commission. The report was entitled, "A Survey and Analysis of the Treatment of Sprain and Strain Injuries of the Back and Neck in Industrial Cases."¹⁹

The purpose of the research was to compare the

- (1) average treatment costs,
- (2) worktime losses,
- (3) services rendered

per case for back and neck injuries as treated by chiropractic and medical doctors.

The study covered 19,666 individual cases and was checked at each stage by the First Research Corporation, a nationally recognized, independent research organization. The findings are related to sprains and strains of the neck, spinal column, vertebrae and back.

The cost of the average case was as follows:

	Handled by	
	Doctor of Chiropractic	Medical Doctor
Total treatment costs	\$51	\$65
Compensation costs	9	37
TOTAL	\$60	\$102

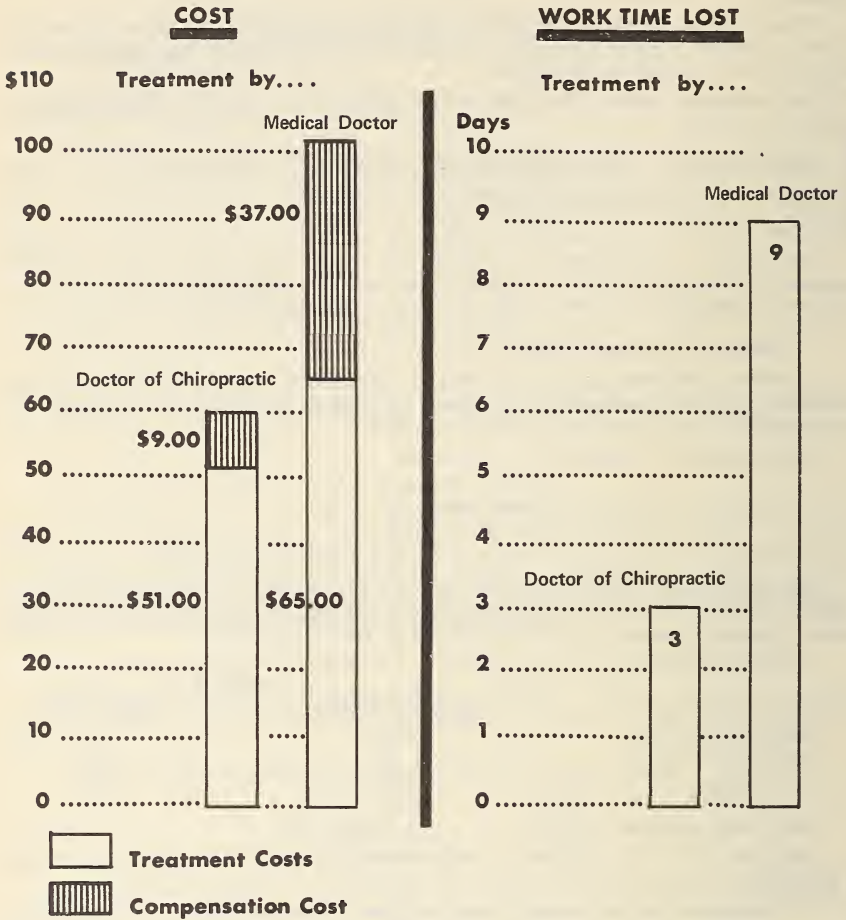
The average worktime lost was	3 days	9 days
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Thus, when a back or neck injury case was handled by a medical doctor rather than a doctor of chiropractic,

- (1) Treatment costs (by a medical doctor) averaged 27.5 per cent more!
- (2) Compensation costs (under care by a medical doctor) averaged 311 per cent more!
- (3) Worktime losses (under care by a medical doctor) averaged 300 per cent more!

BENEFITS FROM CHIROPRACTIC CARE IN SUCH CASES WERE: (1) REDUCED HEALTH CARE COSTS; (2) REDUCED COMPENSATION COSTS; (3) REDUCED LOSS OF SALARY AND PAIN TO EMPLOYEE; AND (4) REDUCED LOSS OF MANPOWER TO EMPLOYER.

Comparison of Costs & Time Loss, Florida Workmen's Compensation Cases



Note: Study of Florida Workmen's Compensation records (checked at each stage by First Research Corporation, a nationally recognized independent research organization) covered 19,666 individual cases related to sprains and strains of the neck, spinal column, vertebrae and back.

2. Other Studies

A report covering 528 cases reported by the chiropractic college clinics* shows the following:

- 223 cases—Discharged (no residual symptoms)
- 11 cases—Discharged under special conditions (no residual symptoms)
- 99 cases—Improved (still under treatment)
- 5 cases—Not improved
- 103 cases—Patient failed to return
- 87 cases—No progress report filed

The average recovery time for 223 of the discharged cases was 29.69 days.

IV. TRUE ISSUE NO. 4—STATES' RIGHTS AND FREEDOM OF CHOICE

Issue: Will the Federal medicare program run roughshod over States' Rights? and over the patients' freedom of choice of health services?

Fact: This is for Congress to determine.

The very first two sections of the medicare law are captioned as follows:

1. "PROHIBITION AGAINST ANY FEDERAL INTERFERENCE," Section 1801
2. "FREE CHOICE BY PATIENT GUARANTEED," Section 1802

In its present form, the medicare law violates both of these principles by its failure to include coverage for the health services provided by doctors of chiropractic and other healing arts.

STATES' RIGHTS

As already noted, forty-eight states, Puerto Rico, and the District of Columbia have licensing laws which recognize the practice of chiropractic and authorize its health services for their citizens. Therefore, the Federal medicare law, by denying coverage of chiropractic services, interferes with the operation of such States' laws within the respective state boundaries, contrary to Section 1801.

PATIENTS' FREEDOM OF CHOICE

If there were one continuing thread during the entire Congressional debate on medicare, as well as in the prior twenty years of discussion, it was Freedom of Choice by the patient to obtain health services from any licensed provider thereof. The non-inclusion of chiropractic services in medicare represents a denial of the Freedom of Choice Congress guaranteed in Section 1802.

Denial of effective States' Rights and Patients' Freedom of Choice in Title XVIII of the Social Security Act (medicare) is all the more paradoxical because true States' Rights (and the coverage of chiropractic services) are allowed in Title XIX (medicaid). Of the states which have adopted medicaid legislation, seventeen now include chiropractic services.

Thus, we have the following inconsistent result under the present Social Security Act:

1. THE MEDICALLY INDIGENT CAN OBTAIN CHIROPRACTIC SERVICES UNDER MEDICAID (TITLE XIX),
2. BUT THE PERSON OVER SIXTY-FIVE WHO VOLUNTARILY CHOOSES AND PAYS FOR MEDICARE CANNOT OBTAIN CHIROPRACTIC SERVICES UNDER TITLE XVIII.

*Higley, H.G., M.S., D.C., "Study of Low Back Pathology," July, 1965.

CONCLUSIONS

The facts are:

- (1) There is a need for chiropractic service, especially among the Medicare age group;
- (2) Chiropractic is an effective form of health care;
- (3) Chiropractic is licensed by 48 states;
- (4) Chiropractic benefits in Medicare will not create any adverse cost problem;
- (5) The Federal government already recognizes chiropractic in a wide variety of laws, including medicaid, civil service, income tax, and immigration.

RECOMMENDATION

The Congress should amend the Medicare law by allowing Medicare patients Freedom of Choice to select the services of doctors of chiropractic.

American Chiropractic Assn., Inc.
2200 Grand Ave.
Des Moines, Iowa 50312

International Chiropractors Assn.
741 Brady Street
Davenport, Iowa 52803

Council of State Chiropractic Examining Boards, Inc.
2811 Central Ave.
Cheyenne, Wyoming 82001

FOOTNOTES

1. H.E.W.—List of Ad Hoc Consultant Group-Appendix A to H.E.W. “Independent Practitioners Under Medicare,” Dec. 28, 1968.
2. H.E.W. Expert Review Panel, *Ibid.* Note 1.
3. Haynes, G.H.—A Study and Evaluation of Chiropractic Education, 1969, unpublished.
4. Adapted from Unpublished Study, Note 3.
5. Adapted from Unpublished Study, Note 3.
6. J.A.M.A.—Medical Education in the United States. November 25, 1968, Vol. 206, No. 9, at page 2014.
7. Palmer College Faculty Survey, 1969.
8. Los Angeles College of Chiropractic Faculty Survey, 1969.
9. General Committee on Education of the Profession, 1962. “List of Textbooks.”
10. *Ibid.* Note 8.
11. “Chiropractic Survey and Statistical Study”—Batten and Associates, Inc., 1962, page 30.
12. Letter from U.S. Department of Justice—April 25, 1967.
13. Brown, P.—Report, Legal Department of California Chiropractic Association, 1966.
14. P.H.S.—National Center for Health Statistics, Series 10, No. 28, page 37.
15. Florida—A Survey and Analysis of the Treatment of Sprain and Strain Injuries of the Back and Neck in Industrial Cases. (Florida Workmen’s Compensation Records), 1960.
16. Higley, H.G.—Chiropractic in Public Assistance Medical Care in the State of California. The Chirogram, Vol. 35, No. 3, March, 1968.
17. Survey Completed in 1968, unpublished.
18. Higley, H.G.—Summary of Cost of Chiropractic Care of Industrial, Auto and Other Injuries Involving the Spine in the State of Oregon. The Chirogram, Vol. 35, No. 1, Jan., 1968.
19. *Ibid.* Note 15.

Mr. BARNHART. Mr. Chairman, I am sure that myself or any of the other witnesses will be happy to answer any questions that any of the committee might have.

Mr. BURKE. Are there any questions?

Mr. BYRNES. Mr. Chairman.

Mr. BURKE. Mr. Byrnes.

Mr. BYRNES. What are the 17 States that include chiropractic in medicaid, in title XIX? There are 17 of them out of the 50 States.

Mr. ROSENFELD. California, Idaho, Iowa, Illinois, Kansas, Massachusetts, Michigan, Minnesota, Nebraska, New Mexico, New York, North Dakota, Ohio, Oregon, South Dakota, Texas, and West Virginia.

Mr. BYRNES. Are the States that require commercial insurance to cover chiropractic those same 17 States plus two more?

Mr. ROSENFELD. There are some differences, sir.

If you will look at footnote 6 of Dr. Brassard's statement, those States are California, Connecticut, Delaware, Illinois, Indiana, Maryland, Massachusetts, Michigan, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, Ohio, Rhode Island, Utah, and Virginia. There is some overlap, but by no means complete.

Mr. BYRNES. I assume that since there is no restriction under the Federal law, as far as title XIX is concerned, it would cover any other medical care, or any type of remedial care recognized under State law, and I assume that in those States that do not include chiropractic in medicare, your groups have been active in attempting to have their laws cover medicaid.

What is the principal rationale that is given in those States for not covering chiropractic?

What I am trying to point out here is that even though 48 States do license doctors of chiropractic, and even though the States are authorized to cover chiropractic under medicaid, still less than half of the States do recognize chiropractic expense as an appropriate item under medicaid.

I think that is one of the problems, frankly, that the committee faces as it looks into this question.

Dr. DAY. Mr. Byrnes, if I may, I would like to answer that question.

There are a number of States, including my own, which could be added to that list, because in the last session of the legislature we did include chiropractic under medicaid coverage. However, the program is not in action yet, and the reason we did not modify our formal statement is that the program had not actually begun. The reason it has not begun is that the Department of Health, Education, and Welfare brought down another ruling as of the 1st of July which has to do with the percentile of payment of all vendors. Thus the Department had to back up and change its mechanics and its fee schedule, and is now in the process of finalizing a survey to discover what the true fee schedule was as of January 1, 1969.

Mr. BYRNES. Is there any other State that has enacted legislation but is not yet operative?

Dr. DAY. There is, but I cannot name it for you at the moment. But there are two other main reasons why the legislature has been reticent to expand the medicaid program, and of course one of these was discussed this morning, the tremendous increase in medical costs.

In our State, for example, hospital costs have become so high my

interim committee has just completed, at the end of the last biennium, an in-depth study on hospital costs. This even brought before us the possibility of utility-type control over hospital costs, because they are ballooning so the demands for money from our budget. Therefore, any attempt to increase or enlarge the scope of care under medicaid met legislative difficulties.

Of course the other reason is the same opposition that we have here today, the American Medical Association, and they are powerful.

Mr. BYRNES. Are these States that left the coverage of chiropractic under their medicaid the States that have a greater limitation on what doctors of chiropractic are permitted to perform?

It does vary. You recognize that factor in your statement, that there is variance, but do you find any corollary between the two?

Mr. ROSENFELD. No, Mr. Byrnes; there is none. I think it important to bear in mind that many of the States that have had this in mind have been deterred not only by the administrative development that Dr. Day has mentioned, but also by an additional fact, of which this committee is aware, the congressional proposals for the limitation of the areas in which medicaid matching could be made. As a result, the States were saying:

If this is to be a State-Federal matching program, and if the Federal Government is to change the rules of the game, we had better wait until we know what the rules of the game are before we come in on it.

And this has meant, and we understand why, a very serious restriction on additional States coming in, where they did want to do so.

Mr. BYRNES. Maybe your actuary can answer this question.

You do have 19 States now that require commercial insurance to cover chiropractic and you stated that you did contact insurance companies covering some 44 percent of the basic health insurance coverage. Is that correct?

Mr. BARNHART. Yes, sir. That is correct.

Mr. BYRNES. I assume these companies operate in most of the States?

Mr. BARNHART. Yes; nearly all of these carriers are multistate, operating perhaps in all but one or two States, at the least.

Mr. BYRNES. Can you tell me this: Do they have a different premium in those States where they do not cover chiropractic services than in one of the 19 States where they do have to carry chiropractic? Do they have a difference in premium as a result of that factor?

Mr. BARNHART. No, sir. They do not, with one exception. There are some group plans where chiropractic care has been added to the group policy in the form of a rider, and in these cases there has been a small premium charge, simply because of additional coverage to the contract.

But wherever plans are being offered on a multistate basis, particularly individual contracts, there is no change. I was not able to discover any instance at all of a change in premium rate resulting from the fact that chiropractic care was included in one State and perhaps not covered in another.

Mr. BYRNES. If this is an item of cost, you would think that the private companies would recognize this just as much as the States would be considering the element as an additional cost, and yet the private companies do not. Is that the generalization?

Mr. BARNHART. That is correct. The few that indicated they felt there was any measurable change in cost, generally did not feel that it amounted to more than about 1 percent, a very, very small percentage of their total cost.

Mr. ROSENFELD. Mr. Byrnes, may I make the point that the difference between the States and the commercial companies is the States were bound by a partnership system. Therefore, they could not tell what they were going to be submitting to the Federal Government for reimbursement until they knew the reimbursement rules, and that was why they held back in some instances, whereas there was no such limitation on the insurance companies.

Mr. BYRNES. I am not sure that I understand this limitation that you say was imposed on the States by HEW in conjunction with medicaid. What is that limitation?

Dr. DAY. Of course the limitations that I referred to were the limitations of availability of matching funds, and in our State we have a situation where when the funds are reduced, the only medical care that is available to the indigent is acute and emergencies only, and there is a reduction in drug availability. The drug formulary is cut down.

Mr. BYRNES. It is a dollar limitation, rather than the type of service that is going to be given?

Dr. DAY. Right.

Mr. BYRNES. The State still has the determination as to what services it wants to provide. It is simply the dollar amount that has been imposed as a restriction on the program, with the latitude within the States to decide how they are going to reduce their package so as to conform to the dollar cost.

Mr. ROSENFELD. In addition to that, Mr. Byrnes, there was an effort mounted in the Senate, as you recall, coming out of one of the southwestern States. Because of the unprecedented and uncontrolled rise of medical costs and hospital costs, an effort was made to limit the 15 areas in which services were allowable in medicaid to merely five as a required portion of the medicaid plan. It was this whole ferment that was going on, particularly on the Senate side at that time, as the legislatures were in session, which created so much uncertainty. Thus they said, "Let's wait and see what the rules are," and by the time the rules were settled, the legislatures largely had gone out of session.

Mr. BYRNES. I did not hear anybody express it definitely, but is it is your proposal to provide the same latitude that is provided under title XIX, or is it to simply define the services to include chiropractic service?

Mr. ROSENFELD. It is the latter technique, Mr. Byrnes. The proposal that has been made, and which we urge upon this committee, in an amendment of section 1861(r) to insert a fourth subparagraph which would read substantially as follows:

"Or (4) a chiropractor licensed as such for the State," and I am skipping some other words, "licensed as such by a State, but only with respect to chiropractic services which he is legally authorized to furnish as such by the State in which he provides them."

So that the objective here would be to follow precisely the line that Mr. Conable and Mr. Betts indicated, the State practice instead of having in effect a Federal definition of practice.

Mr. BYRNES. And it is your position that the States that do not include chiropractic services under medicaid, are not doing so because of the cost element?

Mr. ROSENFELD. Well, we must be honest and say I don't think that is complete, sir. There may be some that just don't want to do it, for whatever reason, but so far as we know, that is the primary reason for it: the uncertainty, as both Dr. Day and I have indicated, as to where the reimbursement is coming from.

Mr. BYRNES. But one does run into an analogous situation here, where 19 States require commercial insurance to cover chiropractic, and yet the Federal insurance does not have to comply with that requirement.

Mr. ROSENFELD. On that point, it is well to bear in mind, Mr. Byrnes, that not only do 48 States license and regulate and control chiropractic in the same way that they control every other health service, but 48 States pay for chiropractic services in workmen's compensation, so that the truer guide for Federal inclusion of chiropractic in medicare is in that 48. The 17 that you have mentioned in medicaid, and the 18 in the insurance equality laws, are now rising up to that other level.

For example, there has been an increasing acceleration in the last year or so on these insurance equality laws, because of the very point that you make, the recognition of the unreasonableness of any other position.

Mr. BYRNES. What two States don't license doctors of chiropractic?

Dr. DAY. Mississippi and Louisiana.

Mr. BYRNES. What about Guam and Puerto Rico?

Dr. DAY. Puerto Rico does.

Mr. ROSENFELD. And the District of Columbia does, by act of Congress.

Mr. BYRNES. Just so that we get the record clear, all of the States I assume have workmen's compensation laws.

Mr. ROSENFELD. Yes.

Mr. BYRNES. Do they all include chiropractic service?

Mr. ROSENFELD. All but two.

Mr. BYRNES. The same two?

Mr. ROSENFELD. No; I believe one is Maine and one is New York.

Mr. BYRNES. And yet New York covers it under medicaid?

Mr. ROSENFELD. That is correct.

Mr. BYRNES. Maybe you can understand our confusion, then.

Thank you very much.

Mr. BURKE. Are there any further questions?

Mr. Broyhill?

Mr. BROYHILL. Dr. Roth made a statement this morning that the Army and the Navy and the Veterans' Administration did not provide chiropractic services. Is that correct?

Mr. ROSENFELD. Yes, sir; that is correct.

Mr. BROYHILL. Why is that? Have you ever tried to do something about that?

Mr. ROSENFELD. I would be less than honest if I said we did not.

Mr. Broyhill, let me put it this way. I think Mr. Conable put it right on the nose, that the committee and the Congress is caught between two conflicting schools of health service, one of them insistent that it be the one that be controlling. What we are suggesting to you very gener-

ally is that the Federal Establishment is under the control of the dominant one, the M.D.'s. Having heard the view that Dr. Roth expressed, it would be less than the normal thing to expect that his colleagues in the Public Health Service and the Veterans' Administration, the Army and the Navy, would have a different point of view.

This is an institutionalized predisposition on the part of one of the schools of health service.

This committee has faced this same problem before. There is major controversy between the schools of allopathy and homeopathy, and this committee has said, "We will leave it for the States." There is major controversy between both of those schools and osteopathy, and this committee has said, "We will leave it to the States."

And all we are suggesting to you, sir, is precisely that recognition, just as Mr. Betts and Mr. Conable put it. We respectfully suggest that is the wiser decision here, so that chiropractic could be used in accordance with the laws of the States.

Dr. Roth said he was going to go back to the States, and that is the proper place for it. Otherwise, you are faced with a problem of, as Dr. Day has said, taking over medical practice.

Mr. BROYHILL. The AMA has the same general resistance to optometrists being brought under medicare, and yet there are optometrists in the military.

Mr. ROSENFELD. Very, very few, and bills are constantly being put in to increase them.

Mr. BROYHILL. They are in the military.

Mr. ROSENFELD. That is correct.

Mr. BROYHILL. They receive commissions with their appointments.

Mr. ROSENFELD. That is right, and we think that Congress was right in authorizing that. It was authorized by congressional action.

Mr. BROYHILL. Dr. Day, you stated on page 4 that they do a better job in the chiropractic than do the other M.D.s and other services.

On page 4 you point out how the injured workers who use chiropractic get better more quickly.

Dr. DAY. It is true, and the statistics show that, under specific types of conditions.

I think we are getting down here where we have a division of ideology, and where objectively the ideology applies. In fact the answer is forthcoming.

Mr. BROYHILL. What about the danger that Dr. Roth referred to?

Dr. DAY. Of course, when you don't comply with what he feels should be done to the patient, then that, in his mind, is a danger.

Of course, we could reverse that and point up the cases of spinal surgery that have been done where, if they would have had the competent chiropractic care, and the proper decision had been made, the surgery could have been avoided.

This is a common occurrence in a chiropractic office, for the patient who has had spinal surgery to come in and wonder if there was anything that could be done now. In fact, I have had them with four or five surgeries, surgery and repair and then more surgery and more repair, and still the condition is not corrected.

In other words, I am saying that the competitive advantage that is available in our society is not available in the healing arts.

The license granted to practice for all the professions is a privilege granted by the State, and instead of treating it as a privilege, some of the professions have seem fit to treat it as an advantage. With any privilege go the attendant responsibilities, and I think one of those responsibilities should be that we know when we don't know.

Referral between the professions has broken down because of these unwarranted attacks. Statements were made, claims that chiropractic has no basis whatsoever, and then we can turn around and show where the results are concrete, and are there. Contrary to a statement that there is no basis in fact for chiropractic, we could quote right out of the AMA Journal. Dr. Edward L. Compere, in answer to the question, "Is it possible to manipulate spinal vertebrae by hand to relieve underlying pathology," answered in his column in the AMA Journal:

Many Orthopedists as well as Osteopaths have demonstrated that it is possible to manipulate the spinal vertebrae by hand and relieve pressure on nerve roots. The exact nature of the lesion which responds to this type of manipulation has never been fully established.

Mr. BROYHILL. Mr. Chairman.

I would appreciate it if you tell us briefly in your opinion the difference in type of treatment that a person with a bad back would receive from an osteopath and a chiropractor, and a physiotherapist.

Dr. DAY. Basically, osteopathy originally was concerned with manipulation of bones, muscles, ligaments, and joints to stimulate circulation. They would give a general manipulation.

The physical therapist would apply heat, massage, exercise, stretching, this type of thing, rehabilitative exercise, sitz baths, to alleviate symptoms.

The chiropractor is concerned with the spine and its relationship to the nervous system.

Now, here again, the basis for the practice of chiropractic is well founded in statements in Gray's "Anatomy," and in Halliburton's "Physiology." Gray's "Anatomy" states that the nervous system is:

* * * to control and coordinate all the other organs and structures and to relate the individual to his environment.

And Halliburton's "Physiology" says:

Over and above these is the nervous system (brain, spinal cord, and nerves), the great master system of body which presides over controls, and regulates the functions of the other systems.

And certainly this cannot be questioned as an authority in the health field.

Mr. BROYHILL. Would the osteopath deal with the condition of the spine in his treatment?

Dr. DAY. He would attempt to manipulate the spine, yes.

The osteopath has evolved into an osteopathic physician and surgeon. I understand that less than 5 percent of his care now is in the manipulative area. He is doing surgery and giving injections.

Mr. BROYHILL. Would you not become involved in the treatment of bones, as the osteopath does?

Dr. DAY. We would not be involved in the area of anything other than neuro-musculo-skeletal conditions, and their effects.

Mr. ROSENFELD. Mr. Chairman, may I make an observation?

Mr. Landrum asked a question of Dr. Roth relative to the failure of the medical profession to serve rural, nonurban areas, and while

Mr. Landrum is not here, I would appreciate it if you would permit me to make an observation for the record on that score.

Dr. Brassard has submitted for the record a "Chiropractic White Paper." On page 13 there is this one paragraph which I would appreciate your permitting me to read into the record.

The crisis in health manpower is a well-documented fact in American life. Farm and rural families are especially in need of health services, and chiropractic is geographically available to provide such services:

1. A major study of the United States Public Health Service indicates statistically a greater orientation of doctors of chiropractic to rural and non-urban America than is true of other health professions.

2. The President's National Advisory Commission on Rural Poverty reported that only 12 percent of M.D.'s are located in rural areas.

3. A recent chiropractic estimate is that over 60 percent of doctors of chiropractic in 1968 were located in communities having a population of 50,000 or less.

Thus, we submit, Mr. Chairman, chiropractic benefits under medicare would be especially important in meeting the needs of rural and farm people.

Mr. BURKE. The committee wishes to thank the panel of the chiropractic associations for their testimony here today and the evidence you have submitted.

(The following letter and enclosure relative to the chiropractic "White Paper" were received by the committee:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
Washington, D.C.

Hon. WILBUR D. MILLS,
Chairman, Committee on Ways and Means,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: At the current hearings of your Committee on social security and welfare proposals, representatives of the two national chiropractic associations urged the coverage of chiropractic services under the supplementary medical insurance part of the Medicare program and requested that Chiropractic's White Paper be entered into the record. Since this paper was prepared in response to a report by the Department of Health, Education, and Welfare on *Independent Practitioners Under Medicare*, I herewith submit copies of the Department's report and an analysis of the Chiropractic White Paper and request that, if such action has not already been taken, these documents be included in the printed record of the hearings.

As you know, the Department's study was prepared at the request of the Congress and submitted in December 1968, by the former Secretary of Health, Education, and Welfare. Secretary Finch has reviewed it and concurs with the findings and recommendations. (See page 623 for text of report.)

In the over-all conduct of the study, which was concerned with nine other disciplines in addition to chiropractic, the Department had continuing advice from an ad hoc consultant group which included knowledgeable Medicare beneficiaries as well as persons of high standing in the health sciences. The consultants recognized the manipulative skills of chiropractors and the fact that their treatment can provide relief for patients with certain conditions. However, they were gravely concerned by the scope of diseases and conditions treated with these techniques. They came to the following conclusions:

1. Chiropractic theory and practice is based upon the role of the subluxation as a causal factor in disease, the "spinal analysis" as a diagnostic technique, and the "spinal adjustment" as a therapeutic measure. None of these has been demonstrated to be valid through acceptable, scientifically controlled research.

2. Restriction of chiropractic services to "musculoskeletal" conditions, with which they are commonly associated in the public mind, or to spinal analysis and adjustment, would in effect be no restriction at all, since according to chiropractic theory the spinal subluxation has a central role in all departures from a state of good health, and all diseases and conditions therefore involve the spinal column.

3. Exclusion of specific diseases from the scope of chiropractic practice would be similarly ineffective because its effectiveness would depend upon accurate diagnosis, and diagnosis is deemphasized in chiropractic theory.

4. In addition to the deemphasis of diagnosis, the quality of chiropractic education and supervised clinical experience is inadequate to prepare chiropractic practitioners to perform an adequate differential diagnosis and to institute appropriate therapy or refer patients to the appropriate source of therapy.

5. Although chiropractors state that they refer patients, the all-inclusive scope of their practice, as evidenced by the numerous disease categories they treat, indicates that chiropractors recognize very little need for referrals. Appropriate referrals are further rendered impactful by the isolation of chiropractic from other health care resources to which they should logically make referrals.

6. Because of these factors, State licensure laws are ineffective in assuring the health and safety of recipients of chiropractic services.

In view of these conclusions, the consultants could not determine that there was a "need" for chiropractic services and strongly recommended that these services not be covered under the Medicare program.

Sincerely yours,

CREED C. BLACK,
Assistant Secretary for Legislation.

ANALYSIS OF CHIROPRACTIC'S "WHITE PAPER" ON THE REPORT

"INDEPENDENT PRACTITIONERS UNDER MEDICARE"

Introduction

This is an analysis of chiropractic's "White Paper" concerning the recommendations on chiropractic in the report, "Independent Practitioners Under Medicare," which was submitted to Congress by the Department of Health, Education, and Welfare in December, 1968. The White Paper, prepared jointly by the American Chiropractic Association, the Council of State Chiropractic Examining Boards, and the International Chiropractors Association (although later orally disavowed by ICA), was released at a news conference on May 16, 1969, with a news release which stated that chiropractic spokesmen "... accused the U.S. Department of Health, Education, and Welfare of submitting a 'fixed' report to Congress, with false and unreliable information, and charged that it 'exceeded its authority' in a recommendation to exclude chiropractic from Medicare coverage."

The Department's report was prepared at the request of Congress, which directed the Secretary of HEW in Section 141 of Public Law 90-248 as follows:

The Secretary shall make a study relating to the inclusion under the supplementary medical insurance program (part B of title XVIII of the Social Security Act) of services of additional types of licensed practitioners performing health services in independent practice. The Secretary shall make a report to the Congress prior to January 1, 1969, of his finding with respect to the need for covering, under the supplementary medical insurance program, any of the various types of services such practitioners perform and the costs to such programs of covering such additional services, and shall make recommendations as to the priority and method for covering these services and the measures that should be adopted to protect the health and safety of the individuals to whom such services would be furnished.

Although the report included recommendations on nine other practitioner groups, the White Paper and this analysis concern only the section on chiropractic.

After evaluation of extensive materials (submitted to the Department by the two national chiropractic associations) on the historical development of chiropractic, the definition and the clinical and scientific basis of practice, education and training, relationships with other health care professionals and with health care institutions, and costs—all in relation to the health care needs of the elderly and Federal responsibility for beneficiaries under the program—the Department recommended that chiropractic services not be included in the Medicare program:

Chiropractic theory and practice are not based upon the body of basic knowledge related to health, disease, and health care that has been widely accepted by the scientific community. Moreover, irrespective of its theory, the scope and quality of chiropractic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment.

Therefore, it is recommended that chiropractic service not be covered in the Medicare program.

White paper charges related to scope of study

The White Paper charges that the Department failed to comply with the Congressional request for the study: (1) by having the Public Health Service conduct the study, contrary to Congressional intent; (2) by exceeding its authority in ignoring the specific limitations placed upon the study; and (3) by ignoring "... the Medicare beneficiary's need for chiropractic, and the cost of chiropractic services to the government and to the individual receiving service."

The Public Health Service prepared the report for the Secretary because it has primary responsibility for the professional and medical aspects of the Medicare program. In either Section 141 of Public Law 90-248 nor the pertinent sections of the reports of the House Ways and Means and the Senate Finance Committees is any mention made of excluding the Public Health Service from participation in the study. The Congress has not expressed disapproval of assignment of the study to the Public Health Service, either while it was in progress or since the report was submitted to Congress.

The White Paper states "... a conference committee rejected a proposal that [the study] be made by the medically-oriented United States Public Health Service." The House and Senate bills for the 1967 social security amendments contained identical provisions for the study; therefore the study provision was not subject to consideration by the conference committee. The conference committee did, however, eliminate the provisions in the 1965 and 1967 Senate bills which provided for the inclusion of chiropractic services.

Broad interpretation was given to the phrase "licensed practitioners" in the Congressional directive. In view of the intent of Congress in asking for the study, the erratic nature of licensure justifies this interpretation. Theoretically, licensure is to protect the public. In practice it is sometimes sought by a profession as a means of establishing the parameters of its discipline and protecting its title, or it is a method of control through registration, with little effort to set or enforce standards. It was not logical, therefore, to use licensure as the criterion for selecting professions for study; i.e., why study physical therapy, which is licensed, but exclude occupational and speech therapy merely because they are not licensed? Selected for the study, therefore, were those disciplines that provide services used by a substantial number of elderly persons and that had expressed wishes for independent practice coverage in Medicare, or changes in method of reimbursement.

The White Paper states that the report ignored the need and cost items of the Congressional directive. The directive of the study includes four items: (1) the need of covering such additional services, (2) the cost of covering them, (3) the priority and methods of covering these services, and (4) the measures that should be adopted to protect the health and safety of the individuals to whom such services would be furnished.

Although the report concluded that, in order to protect the health and safety of Medicare beneficiaries, chiropractic services should not be included in the program, the report, nonetheless, included discussion and statistical data on the extent to which older people use chiropractic services. The findings of the USPHS study of utilization of chiropractic services cited in the White Paper were reported in detail in the HEW report. Demand as expressed in utilization, however, is not synonymous with need. In order to determine if the elderly need chiropractic services, the services a chiropractor provides were considered first. It was then necessary to evaluate the value and appropriateness of these services as established in scientific research, and the qualifications of chiropractors to provide the services in terms of their education preparation.

Since cost estimates depend on specific services to be covered and on the method of coverage, cost estimates in the several areas of study could be obtained only after the recommendations regarding changes in Medicare coverage were made. As was true for several other services for which no change in coverage was recommended, the cost of coverage of chiropractic services was not estimated since the scope and kind of coverage would have to be known to determine potential costs.

White Paper charge: "A 'Fixed' Report"

The White Paper charges that the report was "fixed" (1) because at least six of the eight members of the expert review panel on chiropractic and "... at least twelve [of the twenty-two members of the Ad Hoc Consultant Group]

were professionally or institutionally prejudiced against chiropractic in view of the position of their professions or organizations," (2) because chiropractic observers were not permitted at meetings of the Ad Hoc Consultant Group and representatives of the chiropractic profession were not included on the expert review panel, and (3) because Dr. John Cashman, Director of Community Health Service and responsible for the staff and consultants preparing the report, was alleged to have "... admitted privately to a representative of the chiropractic profession that he was opposed to chiropractic before the study began."

Review of the composition of the consultant groups and of their procedures during the study substantiates the fact that the study was carried out with as much impartiality and objectivity as possible.

To attempt a study such as this without the chief reservoir of technical and scientific knowledge—the health and scientific professions—would have been impossible. Fortunately, these professions are sufficiently large and diverse to contain within their ranks, particularly in education and research institutions, many persons of independent mind whose dedication to their science and to the public interest comes before their membership in a professional organization. Such persons were chosen as consultants; none was a spokesman for his profession's position on Medicare; four of the physician consultants were not even members of the American Medical Association; and a number of the consultants, both medical and nonmedical, have been "pioneers" in the health field, espousing innovative ideas and policy before they were acceptable generally.

The objectivity of the study would have been greatly compromised if representatives of the ten professions being studied, or of any other organizations with a vested interest in the conclusions to come from the study, had been included in the advisory groups or had been present during decision-making discussions. On the other hand, input from the professional groups being studied was necessary. This was achieved, without jeopardizing objectivity, through two mechanisms: (1) the professional associations were asked to submit detailed reports on their professions, including their views on Medicare coverage and on any other matter they wanted considered; and (2) spokesmen for the associations met with the over-all consultant group to present and discuss their views and to clarify aspects of their theory and practice.

The Ad Hoc Consultant Group advised on the total study, including all ten practitioner groups studied. Hence, in addition to the members of scientific professions previously mentioned, it included other persons with special knowledge of the health and other needs of Medicare beneficiaries.

The Ad Hoc Group itself recognized and discussed two possible sources of bias. The first was from attempts by organized groups or individuals with special interests to influence the study. The Group decided that it would not hear or consider material from any group other than those being studied, and that no outside observers would be allowed lest they influence or inhibit the discussions. Thus, when the American Medical Association contacted the former Secretary of HEW and asked to meet with the Ad Hoc Consultant Group, the Group unanimously agreed that such a meeting would be inappropriate.

The second potential source of bias discussed by the Group was that resulting from the fact that its members were sophisticated, professional persons, well-informed about health matters, and inevitably had opinions on all the practitioner groups being studied, including chiropractic. This was coped with in two ways. First, the Group recognized the potential hazard and expressed determination to put aside preconceived ideas and give each profession a thorough, fair, and impartial study. Second, procedures were planned, as described above, to insure that each profession's view got a fair hearing and that views of competing groups were excluded.

The Expert Review Panel on Chiropractic served as technical and scientific advisors to the Ad Hoc Consultant Group. These Panel consultants met the same criteria as the Ad Hoc Consultant Group regarding professional standing and capacity for impartiality and objectivity. In addition, they had to have special expertise in sciences related to chiropractic, and several of them, through their personal professional interests, had acquired considerable knowledge of chiropractic.

The crux of the charge of bias and prejudice in the White Paper is simply: Is "informed" opinion, such as that represented by the study's advisory groups, inevitably "prejudiced" opinion? Can a group of prominent scientists and other persons, assigned a task such as this study, give fair and impartial consideration to the needs and welfare of Medicare beneficiaries?

The White Paper also suggests that the report was fixed because representatives of the chiropractic profession were not permitted to observe at the meetings of the Ad Hoc Consultant Group. These meetings were not public hearings; they were study sessions at which the consultants, and the representatives of the professional organizations at some sessions, could explore the study issues, ask questions, and express opinions without the inhibition of being continually on public display. Hence, only staff were admitted as observers.

The White Paper alleges that Dr. John W. Cashman (an Assistant Surgeon General of the USPHS and Director of the Community Health Service), who was responsible for the staff and consultants preparing the report, "... admitted privately to a representative of the chiropractic profession that he was opposed to chiropractic before the study began." Dr. Cashman states this is not correct. It is obvious that if, in fact, this were his position, he would not have so stated to someone representing the chiropractic profession. It appears that this is an effort to embarrass Dr. Cashman and question his integrity.

White Paper: "False Issue No. 1—Chiropractic education"

The White Paper objects to the report's findings on chiropractic education, claiming that "... chiropractic education is a highly sophisticated, scientific and professional course of instruction requiring four academic years of resident instruction in colleges of chiropractic." Tables comparing chiropractic and medical school curricula and educational entrance requirements are cited as support of this claim.

The report noted that chiropractic schools offer a wide range of courses similar to schools of medicine and osteopathy. But neither range of courses, nor number of hours in them assures a meaningful educational experience. The significant shortcomings in chiropractic education that are relevant to quality remain as cited in the report:

1. The admission requirements for students are notably low;
2. the educational system does not provide for inpatient clinical training, which exposes the student to the breadth and depth of experience necessary to develop the requisite diagnostic and treatment skills;
3. the faculty teaching required scientific and technical courses generally lack the necessary academic qualifications;
4. the number of faculty, in relation to the number of students, is very low;
5. the profession has failed to establish a nationally recognized accreditation program;
6. there is a major schism within the chiropractic field on theory and practice.

The "White Paper" further states: "The validity of a Doctor of Chiropractic degree is attested to by the United States Office of Education in its most recent edition of the publication *Academic Degrees*, p. 169." The following information was provided by the Office of Education.

The purpose of the monograph [*Academic Degrees*] was to provide a "Dictionary of Degrees" for use by professional educators and the general public. It was not intended to be a guide to personnel in the Office of Education for eligibility determination or any other statutory function; rather, as the introduction states, it was designed to "afford information which will facilitate reduction in the number of such degrees currently offered and in greater uniformity in the use of standard abbreviations to represent them."

Two different methods were used for compiling the lists of academic degrees contained in the monograph, one for those represented as in current use, the other for those reported as not in current use. In addition, a distinction was made between degrees conferred by "recognized" colleges and universities and degrees given by spurious institutions.

Chapter 8, Subsection 18, of the monograph lists the Doctor of Chiropractic as a degree conferred by four recognized colleges and universities; nine other chiropractic degrees are also listed, of which seven are cited as spurious and two as infrequently used.

Since Dr. Eells is deceased, we have no way of accounting for the listing of Doctor of Chiropractic as a "recognized" degree. He indicates that information "on current practices with reference to academic degrees," was obtained from registrars of institutions of higher education listed in *Education Directory, 1959-1960—Part 3—Higher Education*. On the basis of the institutions listed in this Directory, however, we are of the opinion that it was very unlikely that any of them conferred the Doctor of Chiropractic Degree and, therefore, Dr. Eells must have obtained his information from another source. Again, there is

a discrepancy in the publication *Academic Degrees* which suggest that perhaps a typographical error was committed. Chapter IX lists in alphabetical order all of the academic degrees "currently or formerly conferred or offered by American institutions of higher education." On page 236 "Doctor of Chiropractic" is listed as spurious.

We have no way of determining the current usage of *Academic Degrees*. Within the Office of Education it has no bearing at all in determining institutional eligibility for funding. Moreover, the Office does not "recognize" academic institutions or degrees. For purposes of determining eligibility for Federal assistance, the Commissioner of Education is required to publish a list of nationally recognized accrediting agencies and associations which he determines to be reliable authorities as to quality of training offered. This is the extent of USOE's function to recognize.

White Paper: "False Issue No. 2—Chiropractic Philosophy"

Chiropractors entered three objections to the report's discussion of chiropractic philosophy: (1) that the quotations regarding philosophy are from early writings that do not represent modern-day chiropractic; (2) that quotations are cited out of context; and (3) that the report confuses "hypotheses" for "chiropractic clinical findings." In other sections the White Paper objects to all discussion of chiropractic philosophy as inappropriate.

The HEW report quoted only from currently used chiropractic textbooks written by the leaders of the chiropractic profession. Appendix C of the report lists the schools at which these books are used. The staff who performed the search of chiropractic literature were aware of the hazards of distorting authors' meaning when quoting. Hence, quotations were as inclusive as possible. When this was not adequate to avoid distortion, paraphrasing was employed, and this was not objected to by the White Paper. No specific examples of quotations distorted by use out of context were cited.

Staff found no evidence that the philosophy as described in the report is obsolete or inconsistent with present-day chiropractic principles, theory, and practice. A. E. Homewood, D.C., in a book published in 1962 and currently used in seven chiropractic schools (in six as the principal textbook of a course), agrees with this view, as shown in the following quotation:

Original principles

Unfortunately, the principles and theory propounded by D. D. Palmer did not meet the needs of the educators in the early days of chiropractic history and much of his teaching was either lost or distorted by the peculiar interpretations which better suited the circumstances. Therefore, it is necessary to constantly quote from the works of D. D. Palmer to establish the exact principles and separate them from the peculiar ideas and theories from the fertile brains of others. Many of these latter theories do not stand with the light of present day knowledge, yet the teachings of D. D. Palmer will be found consistent with the facts of our present stage of intellectual insight and are likely to be found capable of withstanding investigation in the light of new knowledge yet to be discovered—for these are basic truths and principles.¹

As to the confusion in terminology, there is a considerable semantic difficulty between chiropractic and other health professions in the use and interpretation of a number of terms. This difficulty is nowhere more evident than in this section of the White Paper, which is exceedingly difficult to comprehend outside the context of chiropractic philosophy. Hence, it is appropriate that the White Paper raise the problem in this section on philosophy.

In differential diagnosis, doctors of medicine and osteopathy use clinical observations and findings (or facts) to formulate and test a number of hypotheses until they arrive at the diagnosis or diagnoses that account for their observations and findings. For example, if a patient presented symptoms of a lung condition, the doctor of medicine or osteopathy might test hypothetical diagnoses of emphysema, lung cancer, and tuberculosis against clinical observations and findings.

From the presence of the tubercle bacillus and other corroborative clinical findings, together with negative findings for emphysema and cancer, he would conclude that his hypothesis of tuberculosis was correct and would initiate appropriate treatment. Chiropractors say this is treatment "by hypothesis." A

¹ A. E. Homewood, *The Neurodynamics of the Vertebral Subluxation* n.p.: By the Author, 1962, p. 7. (Submitted to the Public Health Service by the International Chiropractors Association.)

chiropractor would also make clinical observations, and might also conclude that the patient had tuberculosis. However, he would treat him for the "chiropractic clinical fact" of a subluxation, for: "The probability or non-probability of the hypothesis does not alter the chiropractic clinical facts," which is the cause of the "physiology gone wrong" as described in the quotation on page 11 of this paper.

Thus, the White Paper says that "Chiropractic treats the ailment disclosed by the clinical facts, not by hypothesis." (Meaning of "ailment" here unknown.) It is the "chiropractic clinical fact" (i.e., a subluxation) in this sense that the White Paper does not want confused with a "hypothesis", by which is meant a diagnosis of a specific disease. But to other health professions, the relationship of this "chiropractic clinical fact," to the disease process is a completely unproven hypothesis. The theory is acceptable only to those who accept the "basic truths and principles" of chiropractic philosophy, mentioned in the quotation from Dr. Homewood above.

The Department's report recommends that chiropractic subject these "basic truths and principles" to examination through scientific research. Since they are amenable to such testing of validity, and since they are contrary to theories that have been so demonstrated, they are not acceptable as assumptions underlying either a philosophy or a science. Until they are scientifically validated, the scientific community must continue to consider them hypotheses.

White Paper: "False Issue No. 3—Diagnosis"

The White Paper disputes the study conclusion that chiropractors' education and experience do not prepare them to make an adequate diagnosis and therefore to know when to refer patients to another source of treatment, citing as evidence: (1) classwork in diagnosis, textbooks used, and clerkships and externships; and (2) the fact that chiropractors make referrals. The inadequacies of chiropractic education, despite the textbooks used and the attempt to include broad content, are discussed in a preceding section (page 6).

Regarding referrals, the White Paper cites a survey showing that 90.3 percent of chiropractors make referrals. However, the basis for these referrals is unknown. The following quotation is as close as chiropractic literature comes to setting guidelines for referrals:

Nevertheless, there are, indeed, limitations, chiropractic is not a panacea. Some pathologic changes are irreversible. Largescale tissue destruction may make replacement with normal tissue impossible. Again, while chiropractic has much to contribute to the improvement of vision, it cannot, under the conditions of modern life, completely obviate the need for glasses as one grows older, nor can it substitute for the services of the dentist. And while many common infections present no special problems for the doctors of chiropractic, there are circumstances involving infectious agents of unusual virulence and a patient of unusually low resistance in which medical attention becomes advisable.²

Therefore, it appears as if the basis of chiropractic referrals is the severity of the patient's condition rather than the diagnosis. The crux of the relationship of diagnosis to chiropractic is the fact that chiropractic philosophy deemphasizes diagnosis. This was shown in the preceding discussion of chiropractic philosophy (the White Paper's "False Issue No. 2" above), and is stated succinctly and directly by chiropractors in materials submitted to the Public Health Service as follows:

Because of the emphasis constantly being placed upon diagnosis by the medical profession, it is difficult for the average lay person to realize that the chiropractor need not diagnose and therefore diagnosis is unimportant to him.³

For the chiropractor, diagnosis does not constitute, as it does for the medical doctor, a specific guide to treatment. It is not a major goal of the doctor of chiropractic to specifically name a disease. He does not look upon

² American Chiropractic Association and International Chiropractors Association, *Opportunities in a Chiropractic Career* (New York: Vocational Guidance Manuals, Educational Book Division, Universal Publishing and Distributing Corporation, 1967), p. 17. (Submitted to the Public Health Service by the International Chiropractors Association.)

³ B. J. Palmer Chiropractic Clinic, *Neurocalometer, Neurocalograph, Neurotempometer Research* (Davenport, Iowa: By the Author, n.d.), p. 3. Quotation from Preface by L. W. Sherman, D.C., Ph. C., then Assistant Director, B. J. Palmer Chiropractic Clinic. (Submitted to the Public Health Service by the International Chiropractors Association.)

diseases as an entity to be combated. For him disease is a process; it is physiology gone wrong. The problem is to ascertain why it has gone wrong, and what needs to be done to right the wrong. This is a goal not attained by routing [sic], conventional, diagnostic methods.⁴

The report concluded that the inadequacies of chiropractic education, coupled with a theory that deemphasizes proven causative factors in disease processes, proven methods of treatment, and differential diagnosis, results in the following hazards to patients: (1) appropriate treatment could be delayed or prevented entirely, (2) appropriate treatment might be interrupted or stopped completely, (3) the treatment offered could be contraindicated, (4) all treatments have some risk involved with their administration, and inappropriate treatment exposes the patient to this risk unnecessarily.

White Paper: "False Issue No. 4—Cause of Disease"

The White Paper incorrectly cites the report's statements on subluxation as a cause of disease and on the scope of chiropractic practice. Nowhere does the report state that chiropractors regard subluxations as the sole cause of disease. The report, documented with extensive quotations from chiropractic literature, refers to subluxations as considered by chiropractic to be "the most significant causal factor" in disease and, in relation to chiropractic philosophy, as the "ultimate causal factor," and it specifically warns about problems of definition "since the nonchiropractor may not understand the chiropractor's interpretation of this causal relationship." The report specifically states (page 165): "It should be pointed out here that many chiropractors do not believe that a subluxation is the only cause of disease, that spinal analysis is the only diagnostic tool, or that the chiropractic adjustment is the only valid treatment." This is followed by quotations from four chiropractors to this effect.

The White Paper also states that the report "... fails to indicate that the majority of patients treated under chiropractic are suffering from neuro-musculoskeletal problems." The Department's report, on page 163, states (emphasis added): "Thus, although *chiropractors see more patients with musculoskeletal problems* than any other kind, it is apparent that they consider themselves competent to treat a wide variety of illnesses. This belief stems largely from their philosophy or approach to health and disease. As a result of this belief, chiropractors do not limit their practice to the care of patients with musculoskeletal problems . . ." Further, the report cites statistics provided by a chiropractic association (page 158, emphasis added): "In a survey made in 1963 for the American Chiropractic Association, 85 percent of the chiropractors reporting said that they treat musculoskeletal problems most frequently. Approximately 81 percent indicated that conditions other than musculoskeletal ranked first, second, or third among conditions most frequently treated."

White Paper: "True Issue No. 1—Need for Chiropractic"

The White Paper asks whether there is a need for chiropractic, and answers: "Yes . . . The need for chiropractic services is best ascertained by the American people's demand for such services."

Neither demand nor utilization is evidence of need. Nor is recognition by any agencies or organizations, whether governmental or non-governmental, as cited extensively in the White Paper, evidence of need. The determination of need is a clinical matter which must consider (a) the diseases and conditions for which services are required; and (b) the demonstrated efficacy of specific services as therapy for the diseases and conditions.

The White Paper cites the shortage of doctors in rural areas as evidence of need for chiropractors. There is a shortage of practically all types of health manpower in rural areas, as stated by the White Paper, but here as well as in the cities specific services are "needed" only if they are efficacious as therapy.

White Paper: "True Issue No. 2—Cost of Chiropractic in Medicare"

The White Paper claims that the inclusion of chiropractic services in Medicare will add no costs to the program. However, the Office of the Actuary, Social Security Administration, has recently estimated for a member of Congress that the probable additional cost in 1969, to include chiropractic services under Medicare on the same basis as doctors of medicine and doctors of osteopathy, would be \$60 million or 26¢ per month per enrollee.

⁴ American Chiropractic Association and International Chiropractors Association, *Opportunities in a Chiropractic Career* (New York: Vocational Guidance Manuals, Education Book Division, Universal Publishing and Distributing Corporation, 1967), p. 17.

White Paper: "True Issue No. 3—Effectiveness of Chiropractic Services"

The White Paper asks whether chiropractic services are effective in helping sick people, and answers: "Yes. The efficacy of chiropractic is a factual and empiric determination, not a theoretical consideration. Chiropractic must be measured by the result obtained in various types of clinical situation." The research cited in the White Paper as evidence of effectiveness of chiropractic services, however, falls considerably short of the task. One study uses costs as a measure of effectiveness; the other is a tabulation of patients seen in a clinic. Neither study, however, utilized meaningful criteria as a determination of effectiveness. As noted in the report, no valid clinical study, using appropriate scientific controls, has ever been done concerning chiropractic. There have not been valid studies of: (1) the role of subluxation in disease causation, particularly related to diseases other than musculoskeletal; (2) the validity of the chiropractic "spinal analysis" as a diagnostic technique; and (3) the efficacy of the chiropractic "spinal adjustment" as a therapeutic measure for the wide range of diseases for which it is used.

White Paper: "True Issue No. 4—States' Rights and Freedom of Choice"

The White Paper cites Sections 1801 and 1802 of the Medicare law as relating respectively to States' rights and to freedom of choice of patients, and claims that failure of Medicare to cover chiropractic services violates these two sections.

Section 1801 forbids the Federal Government from exercising any control or supervision over the practice of medicine or the manner in which medical services are provided, or over organized settings in which services are provided. Relations with State and local government are not involved. Medicare is a Federal program; it is not a Federally-aided State program, although certain Federal Medicare functions are administered through State agencies. Hence, the Federal Government is responsible—and must remain responsible—for the safety and welfare of beneficiaries, for the line of responsibility is directly from the Federal Government to the citizen-beneficiary.

Section 1802 guarantees beneficiaries freedom of choice among the services offered, specifying "any institution, or person *qualified to participate*" (emphasis added). Medicare is not a comprehensive program; selection of services to be included is based upon the necessity for or the contribution of the service in maintaining or improving the health status of beneficiaries.

MR. BURKE. The committee now will be in recess until 2 p.m.

DR. BRASSARD. Mr. Chairman, thank you very much.

(Whereupon, at 12:50 p.m., the committee recessed, to reconvene at 2 p.m., the same day.)

AFTER RECESS

The committee reconvened at 2 p.m., Hon. James A. Burke presiding.

MR. BURKE. The committee will be in order.

Our lead off witness this afternoon is Mr. Whitney M. Young, Jr. and he will have accompanying him Norman V. Lourie.

We welcome you to the committee, Mr. Young, and your associate.

STATEMENT OF WHITNEY M. YOUNG, JR., PRESIDENT, NATIONAL ASSOCIATION OF SOCIAL WORKERS, AND DIRECTOR, NATIONAL URBAN LEAGUE; ACCOMPANIED BY NORMAN V. LOURIE, PAST PRESIDENT, NATIONAL ASSOCIATION OF SOCIAL WORKERS

MR. YOUNG. Thank you, Mr. Chairman. Shall I proceed, Mr. Chairman?

MR. BURKE. You may proceed.

MR. YOUNG. First of all, I want to express appreciation for Mr. Lourie, who is the deputy secretary of the Department of Public Welfare in Pennsylvania, and for myself.

In this testimony I am wearing a couple of hats. I am appearing as the president of the National Association of Social Workers as well as the executive director of the National Urban League. We don't intend to read our testimony. We would like to hit a few of the high points. We are conscious of your time limits.

Mr. Chairman, the Urban League, which is my official full-time job, is, as you probably know, a 60-year-old interracial social-work agency with affiliates in some 90 cities, a full-time professional staff of a thousand people, and volunteers of over 10,000.

The National Association of Social Workers represents over 50,000 professionally trained social workers with chapters located in practically every city. All of these people are working daily and constantly on aspects of social security and social welfare.

Just summarizing parts of the testimony, we first want to identify our strong support of the concepts, some of the principles, enunciated in the legislation and the President's message, and we will identify those areas where we feel there should be deletions or amendments that will, we think, greatly strengthen it.

The President in his welfare reform message to the Congress stated:

"A measure of greatness of a powerful nation is the character of the life it creates for those who are powerless to make ends meet."

It is generally agreed that we have dismally failed to provide economic security and a decent living standard for some 30 million of our fellow-citizens who are poor.

Just as I said, sir, I have traveled in the last 6 months on separate trips to Greece and to Israel, to Tunisia, to London, and I can think of no single thing that continues to mystify, to confuse the people outside of the United States and embarrass those of us who visit in these areas as our failures in the area of getting rid of poverty in this country.

Many people may be indifferent to this type of confusion and criticism, but you stand with great pride as you listen to people talk about our technological accomplishments, our ability to get to the moon, and then stand with shame as they accurately describe the continuance of poverty in this country, of bad housing, of improper medical care, in a country that has so much.

My appeal is that this type of legislation should be strongly supported, greatly expanded, if for no other reason than we don't want to look like technological giants and moral midgets. The disparity between our affluent majority and the millions that are locked into poverty that denies them even the elementary decencies of life has created a real crisis in our Nation.

I would like to call to the attention of the committee that we do face an entirely different situation today as far as the poor are concerned. For the first time, because of an unusual increase in communications techniques, the poor are fully aware of the difference of their status in life. Furthermore, they are aware of how other groups who, finding themselves similarly situated, had, in fact, through a variety of techniques thrown off the cloaks of poverty.

In addition, the poor today have no allies in young people. I think this will grow. Aside from the issue of Vietnam, I know of nothing that is more distasteful and more repugnant to the youth of our

country than the continuance of poverty and of the fact that 30 million people still are being classified as poor. I predict that when and if we ever get out of Vietnam and it no longer ceases to be the issue, that, in fact, this will be the second front of the so-called "revolution."

My appeal is that this time we not always wait to react to crisis, that we don't wait until we have people marching in the streets as you had in the hunger strikes of the past, when white people were hungry and we had the soldiers' marches, that for once we anticipate the possibility that the young will unleash all of their resentments about poverty and bring us to that kind of crisis and then we will act.

I can assure you I can literally predict that unless we do act, we will be faced with this kind of situation.

The present bill on family assistance which your committee is discussing recognizes the need for a minimum income. We would like to commend the administration for recognizing that there ought to be a Federal standard, that there ought to be a floor. We do not feel that this floor is adequate.

I was interested this morning in learning that back when we had WPA, WPA workers got \$103 a month, which is a little over \$1,200 a year. I don't need to tell you the difference in cost of living when now we are talking about \$1,600, which gives you some idea of the inadequacy of the amount.

We think that people can be demoralized for being given too little, and we certainly think it is inconsistent for the Federal Government to set up a poverty level and then to propose a program that is less than half of what has already been established as necessary for a decent life.

I know in many cities this will not be true, because they have already a higher standard, but in many States it will be true. We believe that the best approach to the welfare system is not to reform it but to replace it. What we need here is a bold new effort, and we propose that the best way to do this is through basically jobs and a manpower program system which provides meaningful jobs at adequate wages, through the implementation of the full employment policy adopted by Congress way back in 1946 but has not been implemented and, secondly, social insurance.

Let me address myself briefly to the job end of this and then ask Mr. Lourie to talk about social insurance.

As I said, as early as 1946 Congress did, in fact, recognize full employment was a legitimate concern but actually little was done to mandate that concern until the passage of the MDTA, the Manpower Development and Training Act of 1962. Each time Government has issued a great deal of rhetoric. They have passed bills. They have talked about the necessity for providing training for the "unemployable," finding jobs for those who were employable. They have engaged in a variety of programs.

There have been different amendments of the 1962 MDTA Act. None of these has been adequate. None has done the task. We would like to make a case for Government being a source of employment. It disturbs us when a group of businessmen nobody could call starry-eyed liberals or emotional kinds of people back in 1966 on a commission, which, incidentally, I served on the National Commission on Technology, Automation, and Economic Progress, said there was a need for over 5 million

jobs just in community service, and that has been ignored. Ignored. That is what disturbs us.

This country today when it found 25 percent of the population unemployed in the early 1930's didn't hesitate to enact WPA, NYA, CCC, and FERA. And nobody accused people of being lazy and nobody accused them of being immoral. Nobody said, "Why didn't you pull yourself up by your bootstraps?" It was recognized they were victims of the economic situation in the country.

Yet when we propose that Government be the employer of last resort, when in many cities around the country 25 percent of the minorities are unemployed and today black people have an unemployment rate of $2\frac{1}{2}$ times that of the white rate, when it is 10, 12, just around the country and goes as high as 25 and 30 in some of our large urban areas, and when we talk about a government as employer of last resort, and it was in 1932 when white people were unemployed, people immediately back away from this, and we are not talking about "make work."

The Automation Commission has already said that there are jobs in community service, education institutions, welfare, home care, urban renewal, sanitation, many jobs. It is not like standing on a shovel like people were doing back in the 1930's under WPA. We are concerned when the administration itself acknowledges that a 4-percent unemployment rate is pretty good. At the same time it is proposing a program which, in effect, says we will take people off the welfare and put them in jobs.

Finally, this section of what I wanted to say is we do want to express our concern about aspects of legislation that call for forced work, for mandatory employment, mandatory work. We think that this is too rigid. To make an arbitrary decision that mothers who have school-age children must go to work seems to me not to be good social planning. It may be far better for the society if they stay and take care of their children.

I think it ought to be judged on an individual basis. I think work has to be available before we can say people must go to work. The training has to be available. There has to be assurances that that work will be in keeping with their interest, their aptitudes, that they will not be exploited, that a violin player will not be sent out to do domestic work.

I think there has to be protection. It has to be within the minimum wage.

Finally, I would hope that—and I am concluding just my initial statement—that we would begin to see this kind of program as an investment rather than an expenditure. I think there has been entirely too much discussion about a possible \$4 billion that would be involved in the implementation of even this very minimum, inadequate program. I think we ought to spend more time talking about what we are now spending, what is the cost of not doing, what is the cost of maintaining people in jail, what is the cost of crime, what is the cost of welfare, what is the cost of helping people to realize their full potential as taxpayers and as citizens, what do we pay for social disorganization?

This country did not hesitate to spend billions of dollars to rebuild Japan, to rebuild West Germany, and so today there are no slums in West Germany. There is no unemployment in Japan.

It seems to me if this country can do this for people in a country who were our former enemies, who helped to kill American people—and I think they should have—certainly they should do it first for the people in the slums of our country, they should do it for black people who have fought and died on the side of America in every war. They should do it for Mexican-Americans, for Puerto Ricans. And our plea is that the charity begins at home, and the best example of the viability of American democracy ultimately will not be in the size of our defense budget but in making that idea work and work right here at home, and today we can't hide the fact that it doesn't work. And everybody knows we have the resources.

The issue is the will, and I am convinced this kind of legislation if expanded and amended so that it becomes meaningful can be a step in that direction.

I would like to ask Mr. Lourie to comment on the social insurance, and then I will wind up with just a couple of minutes.

STATEMENT OF NORMAN V. LOURIE, PAST PRESIDENT, NATIONAL ASSOCIATION OF SOCIAL WORKERS

MR. LOURIE. Both of our organizations take the position that we look upon the social security system as the basic underpinning. It ought to be the basic underpinning of an income-maintenance system. And I think, as your committee probably knows better than anyone else, the amendments to the social insurance program over the years have helped to keep many millions of people out of poverty and the 1967 amendments, we understand, kept nearly 10 million people out of poverty.

Our suggestion is that the committee consider doing the same for the 7 to 8 million people who are beneficiaries under this system but who still live under the levels of poverty as defined by the Federal agency.

I think that you are probably well aware of the fact that 58 percent of the people in this country who receive old age assistance are receiving it because their social security payments are too low. And, while we agree with the forward thrust of the President's proposal to set a \$90 base under an older public-assistance recipient, as a matter of fact, for any adult public-assistance recipient, to have that kind of base on public assistance and not to set the same kind of a base on social insurance, which we look upon as the basic programs, seemed to us to be inconsistent.

Now, we are not experts in insurance mathematics. We don't retain actuaries. But, again, we are not unrealistic. We are not suggesting that this can be done overnight. We lean toward the proposal that a 4- or 5-year phase-in be started to reach a poverty-level base in social insurance.

We understand that this would probably mean raising the wage base to somewhere around \$15,000 and that it would be possible to keep the tax on the individual at 6 percent and also probably exempt lower income people.

We very much support the President's proposal for an \$1,800 ceiling on early earnings and \$1 reduction for each \$2 that a person receiving social insurance benefits would earn.

We do also want to comment very briefly on the fact that we favor a broadened health insurance plan that would cover all Americans. We do not have a specific plan. We haven't worked out the details of a plan, but as a matter of principle we wanted to express this to you.

We also would like to say that so long as we do have the medicare program, we would like to suggest that the part (B) premium be eliminated and paid for out of the insurance tax and out of general revenue.

We think that items like drugs ought to be covered across-the-board for all the people rather than only for older people when they are in the hospital.

With respect to the Family Assistance Act of 1969, as Mr. Young has said, we very much applaud the comprehensive approach that it raises and its direction. We think that it addresses the basic problems and that it creates a climate for some new directions for us in America to consider in public social policy. We don't think it went far enough. We think it has some administrative errors, and we would like to make some recommendations which we think will strengthen and better attain the declaration of purpose and to expedite the achievement of the stated goals.

I will go through these very briefly.

First, we think that the basic Federal income floor ought to be established at some kind of an objective and regularly revised standard. \$1,600 for a family of four is not enough, and there are very few of the States that really have a level that is adequate.

We think that there ought to be one place where the program is administered, and we do favor the direction that is taken. It is a partial direction, but we favor Federal administration because experience has shown that the States simply do not have the resources.

The arrangement that is proposed is extremely complex, and we think it would make it more difficult. While the bill does provide for both upstream and downstream administrative arrangements, we think that we go through a few years under this bill of very complex arrangements where a person would have to go to at least two places to get his eligibility determined.

Third, we think that the adult categories ought to be transferred to the social insurance program with requisite financing in the Social Security Trust Fund being supplied from general revenues. We have spent some general revenue for people over 72 on one or two other occasions, and we think that if we did this, it would leave the working poor which could be merged with the general-assistance population and those who were remaining as eligible for public assistance, and it would be a much smaller group than we have now and under one administration.

With national standards I think we would have a much simpler problem.

With respect to work, Mr. Young mentioned what our recommendation would be. We don't think any single parent family ought to be under a requirement to work, because we think that if we mean what we say about our devotion to family life as an important American institution that we ought to be willing to underpin it and to strengthen it.

I would like to say one other brief thing about the question of women and work. You know, the American work force is already made up of about 40 percent of women, and when you get the women of childbearing age, depending on what color the women are, it is roughly somewhere close to 50 percent of white age that are already in the work force without any adequate means of substitute child care. And we think that is quite a frightening figure.

The other thing I would like to say about work is there is quite a myth about public assistance and work. I have looked at some figures in my own State, and I have looked at some figures that the Department of Health, Education, and Welfare gathers, and a very substantial number of the people who come and go from aid to families with dependent children and general assistance in this country come from employment and go to employment. And very much like unemployment compensation, we would like to submit that in a great many ways the public assistance program is as much a subsidy to seasonal and low-range employers as it is a grant to families with children or to an individual.

Our fifth recommendation is that for those recipients who are required to work, and we do believe that able-bodied people who do not need to stay home and take care of children who come for assistance ought to be required to work, we think that there ought to be some wage standards built in. Aside from the fact that we ought to have some public service to stimulate many of these people who ought to get trained and then cannot find a job, we think there ought to be some wage standards so we can get rid of this business of having public assistance subsidize so much substandard employment.

On day care, many of our women, as I said, do choose to work, and perhaps more would choose to work since so many American women already choose to work. Forty percent of the work force is made up of women, and these women are choosing to work, and we want more to choose to work. I think we ought to produce a day-care program on the same basis as we have begun to subsidize on the Federal basis construction of hospitals, mental health, mental retardation, vocational, and rehabilitation facilities.

We haven't put any Federal money into construction of day care facilities as we have in education, for instance, and all these other fields. While this bill does allow for renovation and remodeling of physical facilities, we don't think it is enough. We think if we want day care, we are going to have to put some Federal dollars in the bill.

Eight, on food stamps, and commodities, and other such programs we would like to submit to you that we think they should be looked on transitory and supplemental and in no way a substitute for an adequate income maintenance system.

Mr. Young mentioned the general attitude of many people around the world, and in our view the continuance of the giving of the food stamps in a money economy is really kind of an unsound approach.

Nine, the Federal leadership, we think, and matching funds at the same level as now ought to be continued to develop a comprehensive program of social services and rehabilitation, because many of the people that we are talking about that come for public assistance, the business of money alone isn't going to help. A lot of these families need help in pulling themselves together socially, personally, psycho-

logically, and the only way we are going to do that is by providing social and rehabilitative services.

We think a good deal of effort ought to be put on family planning education and also on family planning services, on child development services, and on counseling and family guidance, and that type of thing.

Finally, we think that the present provisions of the Social Security Act for education and training opportunities for the staffs of social and rehabilitative programs in the States ought to be continued and, indeed, perhaps enhanced. We are very aware of the fact, as Mr. Young has pointed out, there are so many community service jobs that ought to be filled. We would like to see them filled not only by professional people.

We don't think professional people alone are going to do this job. We think we can get people from the present welfare recipient group, and we can give you many examples how welfare recipients with the use of training provided with Federal funds have turned out to be good civil servants doing fine community work in many of our institutions and agencies, and we would like to see this strengthened.

Now, for a summary, I would like to turn this over to Mr. Young.

Mr. YOUNG. Thank you, Mr. Lourie.

Mr. Chairman, there are just a couple of more points I would like to make.

One, we hear a great deal these days about how giving people welfare, giving people money, assistance directly, encourages slothfulness and discourages initiative. We hear a lot of talk about chiselers and deadbeats.

Our profession, social work, our urban league agency, does not accept this. We believe that people basically want to be independent, that people want to stand on their own if given the opportunity. A society can make a person dependent. A society by giving so little, giving it so late, giving it in a manner that is demeaning and demoralizing to the human being, can make him lose his self-respect and reach the point where he in fact becomes a demoralized person and will make dependency a way of life.

Our effort is to try to give people help when they need it in a way that will prevent the continuance of it generation after generation, giving it to him in such a way that he maintains his self-respect, that he feels he is a victim of economic changes and cycles of employment and unemployment, not that he is a criminal and an inferior kind of person.

Our society has a strange way of making it appear that the only people who get help from the Government are welfare clients. We don't think welfare clients will be corrupted any more than corporations who get defense contracts, and they call them subsidies when it goes to business. They don't call it "welfare." They call it a "subsidy" when it goes to the farmers not to grow things, or they call it "research grants" when it goes to universities. It is only "welfare" when it goes to the poor.

We don't think that welfare clients will be any more corrupted by giving them an adequate living wage than I think defense contractors or farmers are corrupted by giving them 10 times as much.

I would like to, in conclusion, Mr. Chairman, point out the great

dangers that are inherent in considering this legislation. Your committee is inundated with all kinds of page upon page of testimony. You are provided with masses of statistics and actuarial tables and cost estimates and numberless charts and graphs. This is all well and good.

There is danger in it, though, because a statistic or a chart or a graph does not have eyes, and you can't see the individual behind it who actually cries. And I think sometimes that is why people prefer to deal with statistics than with people.

But in this kind of setting it is all too easy to forget that behind these statistics are human beings, people like you, members of this committee, and myself, who are in need, people whose souls cry out in despair, people whose basic, elementary needs for dignity and self-sufficiency must be answered.

It is not enough to tell these people that they must cut corners. As a woman told me the other day, she had not learned to cut corners. She just learned to do without.

While we talk, there is a child sitting in a Harlem classroom whose stomach aches with hunger. To her the favorite subject in the school is lunch. While we talk, there is a man walking the streets of Watts looking for work, agonizing over the rent that was due last week. While we talk, a mother in Mississippi, tears in her eyes, is trying to discover how she can feed her child on the monthly check for \$9.50 she has just received from the State.

These are not statistics. They are people. It is within the power of this committee to enact legislation, and I know the power of committees is highly exaggerated by the press, and you gentlemen would be the first to deny such powers, or the power of Mr. Mills as the chairman. Probably you would say it is highly exaggerated. I think in this case it is true.

I really think this committee and Mr. Mills as its chairman, and most singular powerful man, can make a real impact. And this is why I want you on this committee to forget all the statistics and then try to think about the people involved.

These are not statistics, as I said. They are people. You have the ability to enact legislation, to recommend legislation to the Congress, that will restore independence and dignity to these people and the millions like them in this great Nation.

This "other America" can no longer be ignored, despised, and rejected. The ultimate security of all Americans is dependent upon the success of our efforts to end poverty. The poor have placed their faith in the American dream. They have died in our wars—they are bleeding now in Vietnam. But the promise of America has not yet been fulfilled. It is time for that promise to be delivered. It is time for the adoption of a universal system of social security directed at the prevention of poverty. It is time to hear the cries of the poor, both black and white, and to bring our country together again.

Thank you.

(The prepared statement follows:)

STATEMENT OF WHITNEY M. YOUNG, JR., EXECUTIVE DIRECTOR, NATIONAL URBAN LEAGUE, AND PRESIDENT, NATIONAL ASSOCIATION OF SOCIAL WORKERS, AND NORMAN V. LOURIE, FORMER PRESIDENT, NATIONAL ASSOCIATION OF SOCIAL WORKERS, AND DEPUTY SECRETARY, PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE

Mr. Chairman and members of the Committee, my name is Whitney M. Young, Jr. I am the Executive Director of the National Urban League and President of the National Association of Social Workers. With me today is Norman V. Lourie, Deputy Secretary of the Department of Public Welfare for the Commonwealth of Pennsylvania, and a past President of the National Association of Social Workers.

The National Urban League is a nonprofit, charitable, and educational organization founded in 1910 to secure equal opportunities for Black Americans. Its scope has since been expanded to include all minority citizens, and poor and disadvantaged Americans wherever they may be, but our major thrust is for Black people in cities. The National Urban League is nonpartisan and interracial in its leadership and staff. It has affiliates in more than 90 cities and in 36 states and the District of Columbia. It maintains a national headquarters in New York City, regional offices in Akron, Atlanta, Los Angeles, New York, and St. Louis, and a Washington, D.C., Bureau.

A professional staff of about 1,000, trained in the social sciences and in social welfare practices, conduct the day-to-day activities of the Urban League throughout the country. It is assisted by upward of 10,000 volunteers, who bring expert knowledge and experience to the resolution of the problems of minorities and the city.

The National Association of Social Workers is a professional organization of over 50,000 members with representatives from every state in the Union and with chapters in most major cities in the United States.

Its members are involved in the administering of every title of the Social Security Act. Its leadership and members have long sought to eliminate the causes of the major social problems of this country and they work directly to assist those of our citizens in need.

We welcome this opportunity to share with this committee our organizations' thoughts on pending legislation on Family Assistance and Social Security.

The President, in his Welfare Reform Message to the Congress, stated: "A measure of the greatness of a powerful nation is the character of the life it creates for those who are powerless to make ends meet." It is generally agreed that we have dismally failed to provide economic security and a decent living standard for some 30 million of our fellow-citizens who are poor.

The disparity between our affluent majority and the millions locked into a poverty that denies them even the elementary decencies of life has created a crisis in our nation. There is an urgent, immediate need to close the gap in living standards, and to relieve the despair and poverty that afflict so large a portion of the population.

This can be done, in part, through adoption of progressive social security and family assistance legislation. We agree with the President when he says that the present welfare system "is failing to meet the elementary human, social, and financial needs of the poor." And we agree with the Governor's Conference and the Advisory Commission on Intergovernmental Relations in their support for full Federal financing and administration of public assistance.

The present bill on Family Assistance (H.R. 14173) also recognizes this need for a minimum income, but proposes lower levels than are needed. This bill, and related legislation, have opened up a great national dialogue on the ways in which our nation can bring decency and dignity to those left out of the mainstream of our affluent society.

We believe that a strong Family Assistance program with full Federal financing and administration of income maintenance benefits at an adequate level, and the opening up of meaningful job opportunities offer the best hope for solution of the shameful poverty that still curses our land.

We believe that the best approach to the welfare system is not to "reform" it, but to replace it with a new system which assures people in need an adequate income on an equitable basis.

We propose to address ourselves to the development of a universal system of social security directed at the prevention of poverty.

The basic components of our universal system include :

1. *Jobs and Manpower.*—A system which provides meaningful jobs at adequate wages through the implementation of the Full Employment Policy adopted by Congress in 1946; and

2. *Social Insurance.*—A comprehensive and inclusive social insurance program with health care provisions and a level of adequate benefits.

These concepts have already been accepted and endorsed by the Congress, but, in our opinion, have not been fully implemented.

We will also address ourselves to what remains to be done in order to prevent poverty. This will include our evaluation of the proposed Family Assistance Plan and our views on (1) a supplementary cash payment system of income maintenance and (2) a basic social service system that assures competent help at times of crisis or emergency and ongoing professional guidance to maintain family cohesion and stability.

JOBS AND MANPOWER

As early as 1946, Congress recognized that full employment was a legitimate concern of the Federal Government, and, faced with the prospect of a postwar decline in production and employment, it passed the Employment Act of 1946. This was a clear declaration of policy which established federal responsibility "to promote maximum production, employment, and purchasing power." We note, however, that no meaningful action was taken by the Government to mandate that concern until the passage of the Manpower Development and Training Act (MDTA) of 1962.

Two years later, President Johnson called for "an active manpower policy" which would strive to realize each person's highest productive and earning capability. He said the nation must seek to "develop more completely our people's talents and to employ those talents fully—to fulfill the rich promise of technological advance and to enable all to share in its benefits."

Although the Government has exercised a leadership role in recent years, it has proved inadequate to meet the needs of the unemployed, underemployed and the so-called "employables." Since 1962 the field of manpower legislation has been one of constant change. The Manpower Development and Training Act has been amended five times. Title I of the Economic Opportunity Act has been amended twice. These changes are evidence of the need for a more flexible, multipurpose, and interchangeable manpower system. To date, in 1969—nearly a quarter century after passage of the Employment Act of 1946—we have not yet developed a program that assures an opportunity for employment to every American seeking work or provided to every American the education and/or training needed to qualify for employment consistent with his highest potential and capability.

This is the situation despite the findings of the 1966 Report of the National Commission on Technology, Automation, and Economic Progress that there is a need for over 5 million jobs in the community services: jobs in the medical institutions and health services, educational institutions, welfare and home care, urban renewal and sanitation, and national beautification.

In a limited way, the Manpower Development and Training Act has attempted through the Neighborhood Youth Corps and several other provisions of the Economic Opportunity Act to provide opportunities aimed specifically at those left behind in an otherwise prosperous economy.

We hold, Mr. Chairman, that a significant income maintenance program must have as its basic foundation a truly adequate manpower policy and training program that assures a job for every American able and willing to work including jobs in the public services. In our judgment, the bill (H.R. 11620) introduced by Congressman O'Hara and more than 100 other Congressmen—Democrats and Republicans alike—set forth an objective to which we fully subscribe and which we hold must be fully implemented.

That objective says "it is within the capability of the United States to provide every American who is able and willing to work, full opportunity, within the framework of a free society, to prepare himself for and obtain employment at the highest level of productivity, responsibility and remuneration within the limits of his abilities."

We note here, Mr. Chairman, that that objective in terms of manpower policy is much broader than the purpose of the proposed Family Assistance Plan which is limited to expanding "the training and employment incentives and opportunities, including necessary child care services, for those public assistance recipients who are members of needy families with children and who can become self-supporting."

These points are important because the family assistance legislation before us today (H.R. 14173) has a mandatory work clause which we think is too broad and fails to include the concept of employment opportunity for every American citizen who is unemployed or underemployed and seeks to improve his status.

We also believe, as I have already pointed out in a letter to the President, that the compulsory work provisions should be deleted because they are punitive and inconsistent with the facts. Most of the poor, who are able, do work. When they do not work, it is because job opportunities are not available. Poverty itself is the problem. There are gross inequities in forcing acceptance of "suitable work" on one mother with school-age children when another, whose husband works at a below-poverty wage, may remain at home to care for her children if she wishes.

Our primary emphasis here is on a rededication to the 1946 concept which provides meaningful jobs at adequate wages. We are convinced that the most intractable poverty problem today is not in unemployment itself, but in full-time work at low pay, in dead end jobs with little security, and in discrimination in employment.

In a study prepared by Dr. Harold L. Sheppard for the Upjohn Institute he concluded that in any analysis of what constitutes the poor in this country, underemployment looms as large—if not larger—than unemployment. Doctor Sheppard found that almost 5 million people in this country were underemployed. This is significant because it includes by definition people who work and are still poor.

SOCIAL INSURANCE

I. Unemployment compensation

If our fundamental objective is to prevent poverty through job opportunities at adequate wages, we must develop an unemployment compensation system that assures that all beneficiaries are placed above and maintained above the poverty level. The unemployment compensation system should compensate individuals at an adequate level for loss of employment wages and cover a wide range of risks. We are sure you are aware that the unemployment compensation system helps assure a work force for seasonal industries.

The present system of unemployment insurance differs from state to state in terms of coverage, taxation, benefits, and eligibility. The Social Security Act of 1935 incorporated no standards for benefits in the federal-state system of unemployment insurance. There is, therefore, no central pattern of benefit provisions comparable to that in coverage and financing. This means that a worker in one state is not assured the same level of unemployment insurance as a similar worker in another state. We support federal standards covering benefits and eligibility to assure equity in unemployment insurance.

We are aware of the fact that this committee has already considered H.R. 12625, the Employment Security Amendments of 1969, but we feel the necessity of a brief discussion here because unemployment insurance is an important component of our proposed universal social security proposal. While we generally support the recommendations with respect to extended coverage to small employers, the coverage of nonprofit organizations, state hospitals, state institutions of higher education, an extended program for those who have exhausted their benefits, a program of federal grants to train unemployment insurance personnel, and the establishment of a federal advisory council on unemployment insurance, we wish to underline our conviction that the present system must be broad enough to cover all persons in the labor market. Of equal importance is our belief that benefits must be high enough to replace an adequate portion of lost income. This would range from one-half to two-thirds of an employee's earnings while employed. We favor the two-thirds level because we are convinced that the basic purpose of unemployment insurance should be the safeguarding of an "achieved standard of living" as opposed to the simple prevention of poverty.

We believe there must also be special provisions for workers with larger families. Your committee is aware that when a wage earner with a large family draws unemployment compensation, he also must often draw public assistance, too. Eleven states already make provision for dependent's allowances. We support this approach.

To finance the wage replacement and to include all persons in the labor market—farm employment, domestic household workers, employees of small firms—we must increase the taxable wages of employed workers. We hold that the wage base of \$4,200 proposed, although a very substantial increase over the present \$3,000 level, still falls far short in 1969 of the level of taxable wages equivalent to

the \$3,000 level set in 1939 which, at that time, accounted for about 90 percent of all wages paid by covered employers.

Because we believe the objective of an unemployment insurance system should be to cover the widest possible range of risks to enable an unemployed worker to maintain his standard of living by supplying adequate wage loss replacement, the wage base should provide for the financing of such objectives. In our judgment, that should be at least the same base used in the Old-Age and Survivors Insurance (\$7,800 effective in January, 1968), or even as high as the \$9,000 level proposed by the President in his recent Social Security recommendations.

In summary we think the unemployment insurance program should be improved by:

1. Extending coverage to all wage and salaried workers;
2. Providing a minimum of 26 weeks of unemployment insurance, with federally financed benefits in times of unemployment higher than a prescribed level;
3. Permitting participants to attend school, job training or undertake other rehabilitative services while collecting unemployment insurance;
4. Providing benefits equal to at least one-half or two-thirds of weekly wages or, in the case of very low-wage earners, benefits equal to the poverty line or 80 percent of earnings, whichever is less;
5. National standards of benefits and eligibility; and
6. Dependent's allowances so that workers receiving unemployment compensation will not have to apply for public assistance.

II. Social security amendments

We look upon the Social Security system as the basic underpinning for an income maintenance system. It is estimated, for example, that the rise in benefits provided in the 1967 amendments kept nearly 10 million people out of poverty. There still remain, however, 7 or 8 million beneficiaries who are still below the poverty line.

We argue, therefore, that we must now substantially improve the benefit levels under Social Security so as to remove from poverty fully the elderly, the handicapped, and families with children that have suffered the loss of a breadwinner. The President's proposal, as contained in H.R. 14080, with its 10 percent across the board increase in Social Security benefits effective in April, 1970, compensates only for increases in the cost of living, and make no progress toward alleviating the problem of poverty among Social Security beneficiaries.

As a first step in the prevention of poverty for persons who are no longer in the work force, we recommend that the elderly, the blind and the handicapped be removed from the assistance rolls and transferred to Social Security. This would cut the federal public assistance roles by one-third. Currently, something in the order of 1.2 million aged persons are receiving old age assistance—or 58 percent of all those receiving such aid—because their Social Security benefits were inadequate. We note that the President's proposal for establishing a federal floor, \$90 a month, for the needy aged, blind and disabled, as proposed in H.R. 14173, the Federal Assistance Act of 1969, would, with federal and state payments, bring an aged couple to slightly above the poverty line of \$2100. We note further that this proposal provides, at the state's option, for the administration of grants to this group through the Social Security system.

We argue, therefore, that the time has come to declare that no aged, blind or disabled person should have to live at an income below the poverty level, and the most solid way to insure this is to include them in the Social Security system with the cost paid out of the general revenues. Such revenues are already used for special groups.

Such a step, of course, would necessitate an upward revision of the minimum for Social Security to a level of at least \$120 a month. This would be more consistent with the President's Family Assistance proposal. Equity would demand that across the board benefits for Social Security beneficiaries be phased over a three or four year period to produce a 40 percent to 50 percent increase in average benefits. Once an adequate benefits structure is set up, a cost of living escalator should also be included.

To provide for the transfer of the aged, blind, and handicapped beneficiaries to Social Security and an adequate level of benefits for persons already retired or retiring in the several years ahead, provision should be made for a contribution from the general revenues. Such a provision from the general revenues and a wage base moving up to \$15,000 would enable the Social Security tax to be held at a level of no higher than 6 percent for the individual. Additional relief to employ-

ees in the lower income bracket may be obtained by exempting them from payment of Social Security taxes.

Even with these suggested improvements in benefits, only a relatively small percentage of retirees would have income above \$4200 per year for an aged couple, which the Department of Labor has defined as a "moderate" income standard.

We need, therefore, also to give consideration to increasing the amount of earnings a person can have in a year and still get full Social Security benefits. In this respect we support the President's proposal contained in H.R. 14080 for an \$1800 ceiling on earnings, with the provision under which there would be a \$1 reduction for each \$2 earned above \$1800.

With respect to Medicare if it is to be retained—a program of key significance to the elderly and the handicapped—the requirement for beneficiaries to pay insurance premiums of \$4.00 a month for Part B (scheduled to be increased to over \$5.00 in 1970) should be abolished with the cost to be financed out of the Social Security payroll tax and matching contributions by the Federal Government. Furthermore, all drugs and medication prescribed by a doctor should be covered under Medicare instead of as at present only drugs administered in hospitals and other health institutions. We urge further that the disabled be included in Medicare.

Both of our Associations support the development of a universal health plan. While we, of course, endorse Medicare, it seems to us inconsistent not to have a universal coverage program to meet the health needs of families and children. Most experts agree that this nation can and should afford a universal health plan, and it is only through such a plan that we can obviate the present maldistribution of medical services, manpower and equipment which leaves whole areas, millions of people, without adequate, much less specialized, health services.

III. Assessment of the "Family Assistance Act of 1969"

The Administration's proposal H.R. 14173 contains some important concepts which we would like to comment upon before suggesting our own recommendations:

First—We applaud the Administration's recognition that the condition of family income insufficiency is a problem national in scope and consequence and that the Federal Government has a responsibility to resolve this problem by maintaining a floor of income at an equitable and adequate level. However, we firmly believe the proposed annual base of \$1600 for a family of four is far short of the amount needed for family health, nutrition, safety and decency. Full federal financing, bypassing the inequities in additional supplements by some states, would make it possible to insure benefits meeting the poverty level.

Second—We would concur that there is a long overdue need for reorganization in the administration of public assistance programs. From an administrator's viewpoint there now are great inequities between jurisdictions, unbelievable complexities and conflicting regulations with built-in bureaucratic costs. From a recipient's viewpoint there is a need for simplicity, dignity and justice. We believe that the proposed intention to simplify application forms and procedures for recipients is a step forward. In the overall administration, the proposal that the Social Security Administration should assume major responsibility is a move in the right direction. However, in the requested legislation, there are suggestions which compound rather than simplify, and represent a major weakness. Conceivably, a person might have to apply to two, rather than one agency for cash assistance.

Third—We strongly support the extension of coverage so that in all states fathers will be eligible to remain within the family while receiving assistance and especially we approve the inclusion of the "working poor." Despite this forward thinking, the proposed bill makes no provision for several million single adults and childless couples under 65 who are poor and not disabled. General assistance programs, often not available and mostly poorly financed by states and/or local governments are their only resource.

Fourth—We commend the emphasis on providing incentives to self-sufficiency. The inclusion of a work allowance, the retention of 50 percent of one's own earnings and the disregard of certain kinds of income as in the case of students, are all positive inducements to move toward economic independence. However, the work requirements and the sanctions for noncompliance seem to prejudge the motivation of some recipients, and in our opinion to wrongly create a climate of mistrust and coercion. Also, the proposed bill, while providing some resources for day-care programs, does not adequately meet the magnitude of

difficulty for supplying quality day-care. This is a very crucial point. A very substantial part of the workforce is already composed of women, and the percentage climbs even higher for women of child-bearing age. It is not often realized that the public assistance caseload includes hundreds of thousands of people who come and go from the workforce, seeking public assistance when they are laid off or when their wages become insufficient. Often, then, public assistance is less a subsidy to individuals than it is a subsidy to low-wage and seasonal industries.

Fifth—We firmly approve the plan to distinguish between and separate cash payments from the provision of social services. This will free many personnel to provide social and rehabilitative services. We are convinced that for some of the people in need, money alone will not resolve the multiplicity and tenacity of their problems, and that a full range of social and rehabilitative services is required.

Our evaluation of the "Family Assistance Act of 1969" is that it is a comprehensive approach that raises and addresses the basic problems, and that it creates the climate for new directions in public social policy. We wish to make some recommendations which we think will strengthen and better attain the declaration of purpose and expedite the achievement of these goals.

First—The basic federal income floor should be established at some objective and regularly revised standard. A minimum would be the Social Security Administration's poverty index of \$3600 for a family of four. A more adequate measure would be the minimal income set by the Bureau of Labor of Statistics (\$5915). Whatever the level, there should be automatic adjustments to keep even with changes in the cost of living.

Second—The Federal Government should assume full administration of the program. Many states simply do not have the resources. There is inordinate complexity and increased costs in having more than fifty separate state and territory administrations. A single administrative agency is the only way that inequities and inadequacies are going to be eliminated. This would release state and local funds to deal with other severe social problems, and the money thus made available would be equitably related to the state's past efforts to meet welfare needs.

Third—The adult categories (old age, blind, disabled) should be transferred to the Social Insurance Program, with the requisite financing to the Social Security Trust Fund being supplied from the general revenues. The new Family Assistance category, together with the "working poor," could then be merged with the remaining eligible and general assistance population into a single program with national standards, uniform procedures and control of all variables in administrative costs.

Fourth—No mother with school-age children should be required to work, nor indeed should any single parent family be under such requirement, but each should be given the choice of working or staying home, just as in nonassistance families.

Fifth—For those recipients who are required to work there should be federal wage safeguards established in law so that this program does not subsidize or further substandard employment.

Sixth—For those who are given training opportunities it should be with the direct assurance that such training is related to the local employment market, with the firm availability of a job on completion of training including public service employment.

Seventh—The proposed funds for day-care should include provisions for construction, as well as for renovation and remodeling of physical facilities. This is one of the most serious roadblocks to expanding the day-care program.

Eighth—Food stamps, commodities or other such programs should be regarded as transitory, supplemental and in no way a substitute for an adequate income maintenance system. Too often they are cited as a way of closing a "poverty gap" which would not exist with an adequate income program.

Ninth—Federal leadership and matching funds at the 75 percent level should be continued to develop a comprehensive program of social services having national standards but operated in the local community. Such an agency would be available not only to the Family Assistance population, but to the entire community. Suggested services would include emergency and crisis aid, foster care and residential placement, family planning information, education and services, child development programs, counseling and family guidance and use of community programs and resources.

Tenth—The present provisions of the Social Security Act for education and training opportunities for social and rehabilitative staffs of states should be continued. Increased emphasis should be placed on utilization of welfare recipients, the pre-professional “new careerists” and others indigenous to the recipient community. This variety of people and linkage of experience is required to give competent and quality results.

* * * * *

In summary, we believe that the time and opportunity are at hand to enact a comprehensive approach to income assurance. We believe such a program must have the following closely related basic elements:

A manpower program which provides meaningful jobs at adequate wages with the implementation of the Full Employment Policy adopted in 1946. This could be accomplished by the creation of a public service employment system available to all who wish to achieve their full productive capacity.

A comprehensive social insurance program at a level of adequate benefits with national health care provisions included.

A federally financed and administered cash payment system of income maintenance, at an adequate level of assured payment.

A basic social service and rehabilitation system that gives competent help at times of crisis or emergency, and on-going guidance to maintain family cohesion and stability.

Mr. Chairman, we wish especially to point out the great dangers inherent in considering legislation of this sort. Your committee is inundated with pages upon pages of testimony. It is provided with masses of statistics and actuarial tables and cost estimates and numberless charts and graphs. It is all too easy to forget that behind these statistics are human beings—people like yourselves—who are in need. People whose souls cry out in despair; people whose basic, elementary needs for dignity and sufficiency must be answered.

While we talk, there is a child sitting in a Harlem classroom whose stomach aches with hunger.

While we talk, there is a man walking the streets of Watts, looking for work, agonizing over the rent that was due last week.

While we talk, a mother in Mississippi, tears in her eyes, is trying to discover how she can feed her child on the monthly check for \$9.50 she has just received from the state.

These are not statistics; they are people. It is within the power of this committee and this Congress to enact legislation that will restore independence and dignity to these people and the millions like them in this great nation.

This “other America” can no longer be ignored, despised, and rejected. The ultimate security of all Americans is dependent upon the success of our efforts to end poverty. The poor have placed their faith in the American dream. They have died in our wars—they are bleeding now in Vietnam. But the promise of America has not yet been fulfilled. It is time for that promise to be delivered. It is time for the adoption of a universal system of social security directed at the prevention of poverty. It is time to hear the cries of the poor—both black and white—and to bring our country together again.

Mr. BURKE. Thank you.

Are there any questions?

Mr. BYRNES. Mr. Chairman?

Mr. BURKE. Mr. Byrnes.

Mr. BYRNES. I want to thank both of you gentlemen for your statement. I think you have given us a number of very valuable suggestions.

Let me ask this in connection with the emphasis that you put on finding jobs, and I think that is certainly the area to which we must direct our attention. Manpower training doesn't do any good if there isn't a job at the end of the line.

To what degree have the urban league and the National Association of Social Workers been able to address their attention to open up or find new job opportunities? And as part of that question, I would emphasize that I think there has been a failure in the State employment service or USES to act as a really meaningful clearing house of job opportunities. I don't think they necessarily seek opportunities. I

think too many times employers bypass them for help wanted ads or some other procedure. Have you made any survey in your communities of the job opportunities that are available and going begging? Certainly we know there are some and it is just a matter of bringing the two together, the individual and the job.

What has your experience been, and what have you done?

Mr. YOUNG. Yes. Well, it has been a shifting experience. Your observations about the U.S. Employment Service, I would say, were quite accurate, more so in the past than at present.

At one time the Employment Service was not happy or enthusiastic about referring minorities, particularly black people, to companies, because they thought that companies would not accept them, and they would therefore go to the private employment agency in order to avoid having to face up to the rejection. They placed blacks where people asked for blacks. They got their budgets up on volume, placing blacks in low-paying jobs, but didn't place many of the others.

I think this has dramatically changed for the better, but the credibility gap still remains in the black community about the State employment service, and this is why we have contracts today between the urban league and the Department of Labor where we do the outreach and bring people into the employment service. We try to tell them there is change.

The problem of employment we find in our work is really two-fold today. It is not the problem of the placement of the highly skilled person. You don't need an urban league to do that. The skilled black person everybody is looking for. They want at least one instant black or one exhibit A, so there is no problem. In fact, he is probably more than a first-class citizen, you know.

One with a Ph. D. in physics from M.I.T. and black can get another \$5,000. The problem is underemployment rising. Some would have greater potential and get stuck in jobs. They aren't given the chance to move up, sent away to school or given other opportunities.

But I think even more crucial is the problem of the failure to provide training for people who have limited skills and education but who can make semi or quasi-professional contributions, to schoolteachers, to hospitals, and free. Some of the highly limited numbers of professional staff who do this, that could be done by these semiprofessionals.

We have taken some of these people on, people who are basically functionally illiterate but who had great intelligence, and put them in jobs. You take the whole business of daycare today. Our institutionalizing of children in New York is around \$8,000 a year to keep one kid in an institution.

Well, suppose you took a welfare mother and gave her a job of \$6,000 and placed the child with her. She is a good mother, has all the skill to raise a child, so you save \$2,000 and take a person off welfare and give him dignity.

This could be done in the case of hospitals. There are many kinds of jobs.

Mr. BYRNES. Have you conducted activities to search out job opportunities? I ask simply because I just don't know what you have done and to the degree you have done it.

Mr. YOUNG. We do place them.

Mr. BYRNES. I want to compliment you. I get a feeling there are too many organizations sitting around telling State legislators or City Hall or Congress what they ought to be doing when sometimes, because of their location—they are right in the community—they could be doing some work to try to survey the community for potential jobs, jobs that are in existence but are going unfilled. Let government concentrate its help in the more troublesome areas.

I just wonder sometimes whether we are doing all we can do in getting the poor together with a job opportunity.

Mr. LOURIE. Without talking specifically about the Urban League and the National Association of Social Workers, the National Association of Social Workers is a professional group that doesn't work out of the community. The Urban Leagues does a certain amount of placement, but before Mr. Young talks about the Urban League, I would just like to make one comment about what the hazards are.

You know, we live in a free society where an industry or the Government with an airbase or what-have-you can pick up and move it from place to place. We operate that way. Business is opened. Business is closed. Jobs open and close. In other words, there is a very complex kind of relationship between thousands of employers and millions of employees.

Now, we have approached that problem in not a very planned way. If we went about approaching water that comes into this building or the electric system that comes in this building in as chaotic a way as we have approached manpower, we would be in terrible trouble in every building in any big city.

I think one of the very good signs is the administration's proposal to take all of these public manpower programs, of which there are almost endless numbers—I don't think any of us could list them for you—and try to put them together in some kind of sense so that the man in an urban community or in a rural community doesn't have to go to his Congressman or someplace to reserve before he can find his way in and out of these programs.

We have the biggest welter of confusion. Many of these are excellent programs, and each one of them by itself maybe has done a good job, but they really need to be put together in the way we put together our public utilities. That is my view.

Mr. BYRNES. Frankly, I have to say that I think both of you have begged the question.

Mr. YOUNG. Let me try to answer it.

Mr. BYRNES. You have gone around the circle.

Mr. YOUNG. If you did a survey of job vacancies and then you did another survey of unemployment, you are right, you might come out with these balancing off pretty much, but then you have to go to the next point—where are those jobs? Even in a Watts in California, how do they get to the jobs? Are they covered by unemployment compensation? Are they covered by minimum wage? Do they require skills that the unemployed have?

Now, you know what has happened in the society in the last few years. You have tremendous shifts in the type of skills required with the increasing technology. Plants have moved out to the suburbs. How do blacks get to the suburbs? How do they in fact get downtown to apply for a job when it takes a dollar, maybe, for it? A dollar is an

awful lot of money to some of these people who have to come from Watts and have to make three or four transfers on buses.

There are still people like laundry workers who are not covered by the minimum wage. In some cases it is cheaper not to work because there is not an overall coverage, but the big problem is training, and my answer to this would be on-the-job training with the kind of built-in incentives, where the industry would hire, that there would be a job at the end of training, and do this in sufficient numbers.

In the urban league we have this kind of contract, and we have had a 89.5 retention and we have done it at a cost of about \$550 a man. We have trained them in the industry itself.

The answer is not to take people who are beyond school age and try to train them anywhere but in business. And then we ought to do something about our vocational people, turning out people.

I don't know why industry continues to pay twice. They have to pay to train people and pay taxes to have them in school, and the schools turn them out when there is no relation even between what they learn in school and the modern work world. These are the answers to some of the problems.

Yes, there are still lots of jobs going begging and lots of people looking for the jobs, but the getting the two together is the problem.

Mr. BYRNES. But you don't have any direct activity as part of your league operation that is directed to that fact?

Mr. YOUNG. That is right. We do have it, but we don't have enough resources to do it in the volume we would like to. We have limited staff. If we had five times the staff, we would do five times as much.

Mr. BYRNES. Then from your experience, am I accurate in suggesting that today, even with nothing else, we could be putting some of these people to work, because there are some jobs available and there are qualified people for those jobs if only we could get the two together?

Mr. YOUNG. And trained.

Mr. BYRNES. There is a certain level that could go to work right today, and there probably is a job someplace. It is a matter of bringing these two together.

Mr. YOUNG. 60,000 we placed last year. 25,000 we have in on-the-job training programs. In addition, we actually recruited and put into apprenticeship training programs, fellows who are now indentured apprentices, some 1,200 or 1,300.

Mr. BYRNES. You warned us against statistics, but let me ask whether your activities that you have just mentioned show up in any of the national figures of what has been accomplished under work training. Is that part of the Department of Labor's work training program that you are talking about?

Mr. YOUNG. Yes, a part of it, on-the-job training figures. Our own annual reports would show the whole spectrum of things we do in this area. I would be happy to share it with you.

Mr. BYRNES. This isn't just an activity of the urban league?

Mr. YOUNG. There are other groups that are doing it.

Mr. BYRNES. This is part of a national picture.

Mr. YOUNG. There are other groups who are doing this at local levels?

Mr. BYRNES. And your figures are included in the general figures that we have relative to those people who have taken manpower training and have taken on-the-job training, and so forth? What you have accomplished is also in those figures?

Mr. YOUNG. That is right.

Mr. BYRNES. One thing you didn't emphasize—in fact, I almost got the feeling you were ignoring it—was the new emphasis and really a complete change on the working poor in the administration's proposal. You mentioned the findings of Dr. Sheppard concerning the underemployed, and yet isn't that exactly what this program is directed toward?

Mr. YOUNG. Yes.

Mr. BYRNES. And you also put great emphasis on the \$1,600 floor, but really when you look at the whole program, \$3,900 is more the figure in terms of the whole thing because you do have a participation up to \$3,900 just by the Federal Government, irrespective of what New York, or Wisconsin, or Michigan might do as a supplemental.

Mr. YOUNG. That was one of the principles that I said we strongly endorse in the President's speech and in this legislation. For the first time this country was coming to accept the fact that the majority of people who are poor do work and the fact that these incentives in there are very good. But I am thinking that there are States, about 12 or so States, where the \$3,900 is not a realistic figure, even if the State gives 50 percent more. The \$1,600 becomes the ceiling.

I am concerned about this.

Mr. BYRNES. Becomes a ceiling?

Mr. YOUNG. Yes.

Mr. BYRNES. It cannot become a ceiling because as long as you have the working poor program it will go up to \$3,900 anyplace.

Mr. YOUNG. You are talking about the people who can work, the people who are employable and can find the work.

Mr. BYRNES. Right.

Mr. YOUNG. That is great. That is all right. We strongly support this.

Mr. LOURIE. We think that is great, Mr. Byrnes.

One of the things that concerns us is that this deals only with the individuals who have children, that there be a lot of other folks in the States and the localities, each one with a different approach, folks without children, who have very low income, where they are broke or unemployed or have low wages. There wouldn't be any Federal underpinning, so what we say is that this move in this bill to take care of that group of working poor who have children, there is a tremendous advance.

We think it is one of the greatest advances in social policy that we have seen in this country since the Social Security Act has been enacted, but we say, why only the people with children? Look at all the young folks under 65 who don't have children who might be unemployed, who might be underemployed. They won't get a Federal underpinning, and we are suggesting that you consider that.

Mr. BYRNES. Well, I think there is such a thing as trying to take more than you can chew and digest at any one meal, or you may just end up ill and have accomplished nothing. You may not have provided any nourishment. So I wonder whether there shouldn't be a

little greater emphasis on the step that is being taken here and be helpful in that regard rather than to discredit it on the basis that it doesn't go far enough.

Mr. YOUNG. Mr. Byrnes, in my opening statement, I want to make it very clear, we are basically supporting this program. We think it is a step forward. I have said this to the President. I have said it publicly. We do feel that it has shortcomings.

My great fear about this legislation is that it will be defeated by a marriage or coalition of extreme conservatives in this country and extreme liberals in this country, one who will say it is not worth anything because it is not enough, and others who don't want anything to happen at all, and the two of them will get together and defeat it.

Mr. BYRNES. That is why it bothers me. It has not been emphasized enough that this has a pretty good base of beginning, at least in getting some sense out of what is today a most confused area, namely, the present operation of our so-called welfare system.

Mr. YOUNG. Everybody in the country is against the present welfare system. There is no better timing to do it. You see, I don't think there is any middle ground between justice and injustice. I think it is only in the area of human relations that we talk about little chunks, so we don't get choked. We talk about enough to do the job that needs to be done when it comes to a space program or when it comes to defense readiness. We don't talk about whether we give the space scientists too much money that will choke them.

They say if they need so much in order to get to the moon by 1970 we will give to them. We do it in all other areas, but it is in the area of human relations that the people will not choke on \$1,600. We may have to come back with \$1,600, but I think——

Mr. BYRNES. I wasn't referring, Mr. Young, to the dollar amount. I was talking to the breadth of the program more than I was in terms of dollar amounts, because in some aspects talking about \$1,600 for a family of four isn't an accurate description of it. If you are talking about the working poor, the extent of help to a family of four at least goes up to \$3,900 as a minimum, regardless of what the State might do in supplemental.

So I get worried here as some witnesses find only that this doesn't go anywhere near far enough. But yet when you recognize where it is going, from where you are today, I have a feeling that it is a fairly substantial step in the right direction. I think that most of the people would have to admit that. But to say, "Yes, it is, but we just think it ought to go faster or further," that is the kind of thing that makes more difficult the transitional step for an improvement of the system.

Mr. YOUNG. I know nothing that would probably reduce what we have than for all of us to come out and say it was perfect.

Mr. BYRNES. Oh, I don't know that anybody ever suggested any bill is the last word, because that is why each Congress is always amending something that previous Congresses have done. Now we have to do more than amend, I think—in some aspects, practically repeal and build anew.

Mr. YOUNG. That is what I say. I don't think we ought to reform it. I think we ought to replace it. I think this goes a long way toward it.

Mr. BYRNES. Thank you.

Mr. BURKE. Have you any recommendations to make along the lines of the child welfare problem we have in this country? I am referring to the almost 700,000 youngsters in this country who are under child welfare conditions whereby the Federal Government only contributes approximately 6 to 9 percent toward their upkeep. This is in comparison to 50 to 83 percent of the upkeep of youngsters in AFDC.

Mr. LOURIE. Mr. Burke, we are very glad you asked that question. We did not address ourselves to this specifically because we understood that the administration was going to propose another bill in this regard. But since you asked it, I would like to say that both our organizations have always stood for a full appropriation against the authorization that was made in child welfare by the Congress, which never has been met.

I forget the details. I think there was a \$46 million——

Mr. BURKE. I think this year they have gone up to \$57 million and they have an authorization of \$110 million.

Mr. LOURIE. Yes, it is up to 57, so really you have had half of the authorization.

And the second thing that is important to us is that if we really have a national commitment as we say we have to our children, this is one of the areas that ought not to be a closed end.

I have always been amazed at the fact that in the grant program for public assistance and in the social services program for public assistance, Congress has had what amounted to an "open end." In other words, if a child was living at home with his own family in a public-assistance situation, the Federal Government was matching no matter what the caseload was. But when it came to children who had to be removed from their homes in foster care or in institutions, the Federal agency was never allowed by Congress to even get that full authorization, and we feel very strongly that that obligation should be met by the Congress.

Mr. BURKE. Don't you think it is a very sad commentary on the Government to completely ignore these most disadvantaged children?

These children haven't even a mother. They have no one at home to take care of them. They are wards of the States.

This administration and past administrations have completely ignored these youngsters. I wonder whether or not it is because they have no voice or no political muscle or why is it that they just allow these children to exist the way they are. And we know that the conditions in some of the States in this country are scandalous. Ten and 12 children are just thrown out into a home in a rural area, and the people who keep them are paid a few dollars a week.

Lord knows, what kind of food or nutrition they have. Lord knows, what kind of upbringing. Yet they are the future citizens, and there are close to 700,000 in this country.

Don't you think it is shameful and scandalous that this Government of ours can only contribute \$57 million toward their upkeep?

In Massachusetts alone, they are spending almost \$20 million a year on this problem, and I think that all the organizations, yours and everyone else's, should get out and scream to high heaven. Never mind what the administration says they are going to do. Demand it, because there is not a voice in this Nation for these youngsters, and they are our future citizens, nearly 700,000 of them. These youngsters are born

in these hospitals, and they are just turned over to the State. And no one cares about them.

Imagine this great wealthy Government of ours today contributing \$57 million. I hope your organizations will, and you, Mr. Young, because I know that the President will listen to you, bring to his attention the plight of these youngsters. And I have asked this of most of the organizations that have come here. I am not singling you out. But I think it is a scandalous condition in this country when they can allow 700,000 young children to continually be ignored when they contribute 50 to 83 percent to the youngsters under AFDC, and, on the other hand, these children without parents, the Federal Government contributes 6 to 9 percent.

I think you see the picture.

Are there any other questions?

Mr. FULTON. Yes, Mr. Chairman.

I would just like to commend the two gentlemen before the committee for the testimony they have presented. And as a member of the newly organized Urban League in Nashville, Tenn., Mr. Young, I want to report to you that we are making some progress, but not as fast as we would like.

Mr. YOUNG. Thank you.

Mr. FULTON. But we are grateful to you and your organization for not only the leadership but the inspiration that you are giving, have given, and to tens of thousands of people regardless of their class and economic status, regardless of the color of their skin, whether they be black or white. We are indeed grateful for the many contributions that you are making across this land.

Mr. YOUNG. Thank you.

Mr. FULTON. I have one question.

Much emphasis has been and is being put on education, job training, and jobs. I have maintained that it is very difficult for a citizen, even though a recipient of a rather good paycheck each week, to be a real contributing citizen to our society if he does not have a decent home to return to from his daily chores.

If you do have any information with your views on the housing needs in America, I would appreciate it being mailed to my office.

Mr. YOUNG. Thank you, sir. I will. We do have some information we will share with you. I will also share with you that we are increasingly beginning to feel that this has probably as high a priority, if not the highest priority in the future. It is basic to education, the kind of education one gets. It is basic therefore to the job, and the job is basic to the housing.

But the situation in this country has gotten progressively worse. There is not only more segregation in housing today, the North has even more than the South, but the quality and what has not happened in terms of implementation of the very excellent legislation in this field is really frightening. And what we are building up in this country by falling farther and farther back in meeting the housing supply in this country is creating a situation that is going to explode on us one of these days. And we better start talking about some mass production of housing pretty fast in this country.

Mr. LOURIE. I would like to make one comment in reply to your questions, Mr. Fulton.

I am particularly pleased that my own Congressman is here, Mr. Schneebeli, because we have just recently begun in our State to face something. I suppose we should have faced it a long time ago, but I think you ought to be very much aware of the appropriation that is made each year for public assistance.

I suppose I have looked at it, but I am not sure I have ever really looked at it in as clear a way as it has been hit at us recently.

In Pennsylvania we spend each year about \$80 million, State and Federal money, roughly \$45 million Federal and about \$55 million State, on housing for public-assistance recipients, and I say this hit me very strongly because I sat down with the head of the economics department of one of our large universities not too long ago, and I didn't know anything about public assistance, and he was just asking me some questions. And when we got to housing, and I gave him this figure after his questioning, he said to me, "Mr. Lourie, do you know how much housing you could build in Pennsylvania if you had \$80 million a year for amortization and interest?"

I should like to submit to you that we are all together with our public assistance appropriations subsidizing one pile of a lot of slum housing. And if we could be creative to take the \$80 million in our State of Federal and State money and the money that is going elsewhere for this same kind of housing and turn it into something constructive in the way of new housing, we could do something not only for the housing market and meet the problems that Mr. Young mentioned, but we would do something for the industry and for employment in the construction field as well.

That is a lot of money that we are putting into slum housing.

Mr. FULTON. Thank you.

Mr. BURKE. Mr. Schneebeli.

Mr. SCHNEEBELI. I would like to thank, as Congressman Byrnes said, both of you gentlemen for the fine contributions you have made in the past in the field of social betterment. I would particularly like to welcome here my friend Norman Lourie, who has served the State of Pennsylvania for, I guess, over 20 years, haven't you?

Mr. LOURIE. Roughly.

Mr. SCHNEEBELI. He is now a Deputy Secretary of our Department of Public Welfare. He has done an outstanding job. And if the committee will remember, he was before our committee several years ago, when he gave us very good testimony and advice on how to proceed.

Mr. Young, we have heard of your fine accomplishments, and I have a few specific questions here for both of you gentlemen.

Mr. Lourie, when you were here before us previously, you emphasized, I believe, the large number of people who came on and left the public assistance rolls in the State of Pennsylvania for employment reasons. Has this created quite a social problem in this rapid turnover on the employment rolls, and going off the rolls? Has this complicated any of your problems?

Mr. LOURIE. It is a complex administrative problem, and it gives the general impression of very large assistance rolls at any one time, and I have always maintained that when we look at the size of the assistance rolls, we also have to look at where the people came from and where they are going to.

In our State, Mr. Schneebeli, in the last fiscal year that ended July 31, a total of 121,000 cases were opened in the course of that fiscal year, roughly three-to-four people on a case, and about 2½ thousand of that 121,000 came on the rolls because they left employment. They lose income from employment in one way or another. (The document follows:)

NUMBER OF CASH ASSISTANCE CASES OPENED AND CLOSED—ANNUAL DATA FOR PENNSYLVANIA,
FISCAL YEARS 1959-60 THROUGH 1968-69

Fiscal years	Total cases opened			Total cases closed		
	Total	Opened because of employment losses		Total	Closed because of employment gains	
		Number	Percent		Number	Percent
1959-60.....	133,351	54,687	41.0	125,625	50,797	40.4
1960-61.....	142,136	41,686	29.3	126,560	29,051	22.9
1961-62.....	124,168	37,842	30.5	121,710	37,815	31.1
1962-63.....	123,664	41,343	33.4	123,234	39,429	32.0
1963-64.....	117,273	39,023	33.3	122,210	39,871	32.6
1964-65.....	106,036	33,539	31.6	114,521	36,300	31.7
1965-66.....	106,444	29,582	27.8	115,219	31,895	27.7
1966-67.....	112,196	30,814	27.4	103,544	24,038	23.2
1967-68.....	131,697	41,237	31.3	116,999	27,970	23.6
1968-69.....	152,952	55,020	36.0	117,546	31,272	26.6

NUMBER OF AFDC AND GA CASH ASSISTANCE CASES OPENED AND CLOSED—ANNUAL DATA FOR
PENNSYLVANIA, FISCAL YEARS 1959-60 THROUGH 1968-69

Fiscal years	Cases opened			Cases closed		
	Total	Opened because of employment losses		Total	Closed because of employment gains	
		Number	Percent		Number	Percent
1959-60.....	108,087	52,936	49.0	101,903	49,864	48.9
1960-61.....	117,903	40,013	33.9	102,948	28,258	27.4
1961-62.....	101,460	36,467	35.9	97,432	36,955	37.9
1962-63.....	101,664	40,029	39.3	99,709	38,623	38.7
1963-64.....	95,501	37,673	39.4	99,763	38,930	39.0
1964-65.....	83,831	32,128	38.3	91,668	35,248	38.4
1965-66.....	76,106	28,010	36.8	84,990	30,646	36.1
1966-67.....	80,079	29,011	36.2	76,590	22,952	30.0
1967-68.....	102,206	39,073	38.2	86,680	26,754	30.9
1968-69.....	121,094	52,573	43.4	87,944	28,572	32.5

PERCENT OF AFDC AND GA CASES OPENED AND CLOSED BECAUSE OF LOSSES AND GAINS IN EMPLOYMENT—
SEMIANNUAL DATA FOR PENNSYLVANIA AND THE UNITED STATES,¹ 1966-68

	Percent of total cases opened				Percent of total cases closed			
	AFDC		GA		AFDC		GA	
	Penn- sylvania	United States	Penn- sylvania	United States	Penn- sylvania	United States	Penn- sylvania	United States
January to June 1966.....	37.3	42.6	32.3	40.7	43.5	34.8	26.2	25.5
July to December 1966.....	37.6	41.3	34.3	41.5	37.1	33.9	23.4	25.0
January to June 1967.....	38.0	44.4	33.6	42.9	35.9	34.9	20.4	24.1
July to December 1967.....	38.8	43.1	34.8	49.6	34.9	32.9	20.8	24.3
January to June 1968.....	40.3	42.6	37.6	45.9	39.7	36.9	23.6	25.4
July to December 1968.....	41.5	39.0	43.4	46.6	35.1	31.1	26.1	18.3

¹ Source of U.S. data is Department of Health, Education, and Welfare; NCSS Report A-5, published semiannually. Data for this report are submitted on a voluntary basis and the number of States reporting data on AFDC varies from 19 to 30, while the number reporting on GA varies from 7 to 13.

Mr. SCHNEEBELI. Well, aren't a lot of these people taken care of for the time of unemployment by the Unemployment Compensation Act?

Mr. LOURIE. Yes.

Mr. SCHNEEBELI. As far as the social-financial problem is concerned.

Mr. LOURIE. But a great many of them are just like with the old age assistance, very large families or families that are too large to be maintained on the roughly \$46 a week. So what happens is that they get public assistance along with it. Then, of course, a lot of these cases were closed. I guess about 88,000 cases were closed in that fiscal year, and about 28½ thousand of those went to employment, you see. So there is a constant moving on and off employment, and we think that we are subsidizing seasonal employment in this way.

We are not against it, but it is just a matter of fact in public assistance, contrary to general opinion, and I know that it is not your point of view, because you folks have been, you know, steeped in this. But the general public impression about public assistance is that people are just hangers on and just taking money out of the public till.

Mr. SCHNEEBELI. But to a large degree it is a supplement to unemployment compensation.

Mr. LOURIE. We think that is true.

Mr. SCHNEEBELI. Mr. Young, since you operate on a national basis, what is your reaction to the job that private industry is doing in job training? I am particularly thinking of the commission that President Johnson appointed, headed up by Henry Ford II. I think they had a goal of 100,000 people to be trained, and I think they went way over the goal by 40,000 jobs.

What is your estimate of the job they are doing?

Mr. YOUNG. I think one of the most encouraging developments—and there aren't many in the whole field of race relations, civil rights—has been the rather new, belated but sincere interest of American business.

Mr. SCHNEEBELI. You say "sincere." Is it effective?

Mr. YOUNG. Yes. Well, let me get to that. I think their enthusiasm is matched sometimes only by naivete. Their desire to do is not always consistent with what to do.

The particular program you refer to, the National Alliance for Business, was very successful. It shows what business could do when it set specific goals and tasks.

They initially thought they were getting people who would be sort of drains on their employment rolls. They were surprised how people came with limited education and turned out to be excellent employees. The turnover was not high. They did a very good job on the long-range employment, but in the summer program they didn't do as well.

It has been continued by President Nixon under Mr. Kendall, chairman of the board of Pepsi Cola, who took Mr. Ford's place. He has expanded it a bit to include upgrading and not just hard-core. And I am delighted about this, because I think that we have to look at the average and we can't just deal with the hard-core. We have to deal with the soft-core.

Where industry has not done a job yet, I think, is in the area of exerting its influence in the community in terms of educational opportunities, housing, or even attitudes. I am very much concerned about the whole question of polarization today and the troubled American,

and I don't think business—I think business still too much feels that its role begins and ends with employment, and that is not enough. They have a status and a prestige, and they ought to get involved in some of the community things that affect the employment.

Mr. SCHNEEBELI. But they have made a good start, and it is going to be a continuing, ongoing program.

Mr. YOUNG. No question.

Mr. SCHNEEBELI. This ties in with your premise that on-the-job training is so much more successful than some idealistic nonrelated training, and this seemed to me in two or three instances is so much more worthwhile.

The Government doesn't pay for it particularly, to my knowledge. It is for a specific job, and industry certainly will train these people for something specifically within their own organization. And it seems a so much more practical way of doing this.

Can you tell me on the matter of job training, are the community colleges and the junior colleges adapting their education somewhat to training and upgrading of jobs?

Mr. YOUNG. No, I don't think they are. Certainly they aren't nearly enough. There is still a gap, this lack of communication, between the producer of skills and the user of skills.

Mr. SCHNEEBELI. But aren't some of these community colleges changing somewhat from the liberal-arts concept and going into the trade-artisan type of training?

Mr. YOUNG. Night schools, extension departments, those community colleges, but this is a very difficult thing to get a college to do, to move away from so-called liberal arts. Their status, their prestige sort of depends on being involved, and people need liberal arts. They have to be citizens as well as workers.

But I still think that we have to look at technical schools, we have to look at vocational schools, make them far more relevant. We have to think of 2-year colleges, where people are going specifically to learn to be a draftsman or to learn some skill. I don't think we have enough of that yet.

Mr. SCHNEEBELI. Mr. Lourie, in the State of Pennsylvania, I think some of our community colleges are doing a pretty good job of technical training. In the one we have up in Williamsport, 2,000 or 3,000 are in that course all the time training for such jobs as bricklayers, diesel operators, electronics, and so forth.

Mr. LOURIE. We were fortunate in Pennsylvania because we started with a number of technical institutes, and then when our community colleges came, we got even a number of them to be in a sense like technical institutes. And that is moving along very nicely.

Mr. SCHNEEBELI. What experience do you gentlemen have with OIC with regard to underemployment and upgrading of jobs?

Mr. YOUNG. Certainly the one in Philadelphia under Leon Sullivan—

Mr. SCHNEEBELI. We have one in Harrisburg, which I visited three or four times, and I think it is excellent.

Mr. YOUNG. I would have to say they are like urban leagues. They are sporadic. Some are very good, and some are very bad. A lot depends on leadership.

Mr. SCHNEEBELI. Is that parallel to your type of training in urban league?

Mr. YOUNG. To a degree but not much. They usually do their own training, and I question this, frankly. I don't think the place to train people for the modern work world is outside of the job. You know, what happened initially was they gave the black people a building and then the industry gave them a lot of old equipment and stuff that they weren't using, couldn't use, and black people were in there busy learning skills on obsolete machinery. And I don't think that is good, and I think to a degree that they have modernized the machinery—but I go back to my point—the place to train workers who are beyond school age is in the plant itself and not in some building down the street.

Mr. SCHNEEBELI. Thank you very much.

Mr. BURKE. Thank you.

There being no further questions on behalf of the committee, we want to thank both of you. You did an excellent job.

Mr. YOUNG. Thank you very much.

Mr. BURKE. Our next witness is the American Association of Homes for the Aging, Rev. William T. Eggers, Edward A. Munns, and Lester Davis.

We welcome you to the committee. If you will introduce yourself and your associates, you will be recognized.

STATEMENT OF REV. WILLIAM T. EGGERS, PRESIDENT, AMERICAN ASSOCIATION OF HOMES FOR THE AGING; ACCOMPANIED BY EDWARD A. MUNNS, CHAIRMAN, COMMITTEE ON RELATIONS WITH GOVERNMENT PROGRAMS, AND LESTER DAVIS, EXECUTIVE DIRECTOR

Reverend EGGERS. Thank you.

I am Rev. William T. Eggers, administrator of the Home for Aged Lutherans, 7500 West North Avenue, Wauwatosa, Wis. I am president of the American Association of Homes for the Aging, the national membership organization of nonprofit homes. With me, to provide additional informal testimony and also to respond to any questions the committee may have, to my left is Mr. Edward A. Munns, president-elect of the association and in this past year chairman of our committee on Government relations, and to my right Mr. Lester Davis, the executive director of the association.

We have a prepared statement which I will present, and then Mr. Munns will make a brief statement and then, if you have any questions to ask, we will be glad to answer them.

It is a pleasure and a privilege to be able to share with you today the views of the association and its member homes on matters which, in the opinion of the association, should also be of deep concern to the committee and the Congress as it considers modifying current social security legislation to make its provisions, including those of medicare and medicaid, more equitable and adequate to meet the changing needs of older people.

The association commends the present administration in providing the opportunity to explore new alternatives and permit the Nation to obtain a fresh perspective on this difficult and complex subject. The

association applauds the willingness of the administration to expand Federal responsibility as far as benefit coverage and increased payments to older people are concerned. It would seem to the association that the only equitable method of guaranteeing an adequate standard of living for older people and providing adequate care for them in an inflationary period is to create a mechanism which ties the levels of benefits to them to the cost-of-living index and, possibly, to other indices which might prove appropriate.

Moreover, were it possible to create a range of benefits which would eliminate the necessity of beneficiaries to seek supplementary assistance, except in extraordinary circumstances, the association believes that our society would have achieved a noteworthy ideal. Although it is realistic and takes up some of the points that Mr. Byrnes made before.

In commenting on various phases of the Health Cost Effectiveness Amendments of 1969, the association notes that these amendments touch on some of its deepest concerns, which it has previously expressed in documents reflecting association policy, and omits other concerns which are of great significance to the older people of this Nation. With the permission of the chairman, I would like to submit as part of the association's testimony a number of the association's vital documents for the committee's consideration and make brief references to them in my comments. The committee should know that these documents, attached to this testimony and mailed separately to the committee, reflect the widely expressed concerns of homes for the aging across the country.

The American Association of Homes for the Aging fully endorses the intent of the Health Cost Effectiveness Amendments of 1969; that is, to achieve maximum efficiencies and provide services to the aging at the lowest possible cost, while at the same time maintaining quality of care. As one method of helping to achieve this laudible goal the association adopted in 1968 and would call to your attention at this point a document entitled "Unification of Certain Aspects of Long-Term Health Care."

The chief principle enunciated in this document is that increased efficiencies would be obtained through the establishment of a single reimbursement formula for long-term care facilities, a single annual survey of them, and a single annual audit of them. The association understands, of course, that the single reimbursement formula—which would entail uniform and standardized accounting procedures—would have to be appropriately modified to fit several different levels or categories of care within institutions and that such modifications would also be necessary in the single survey of a facility. The association again commends to Congress the concept of these unifications and happily notes that other testimony has begun to express similar concerns for a simplification of what has become a series of unwieldy and time-consuming procedures. The association urges that the goal of this simplification be pursued by the committee and Congress.

It is, moreover, a matter of record that the association has believed, from the inception of medicare and medicaid, that titles 18 and 19 should so closely mesh with each other that the recipient of medicare

reimbursement, whose benefits become exhausted or whose improved condition makes him ineligible for additional medicare benefits, should continue to receive the kind of care necessary for his condition under assurances that title 19 moneys, if he has fiscal needs, are available to him.

Ideally, these two programs should supplement each other and, ideally, unless the patient's condition alters so significantly or drastically that he needs to be transferred to a hospital, he should continue to receive nursing care in the same facility, in fact, in the same room or bed. It is one of the cardinal principles of the Association, which it is pleased again to enunciate, that the amount and level of care that the patient receives should be determined, not by the fiscal mechanism created for reimbursement purposes, but by his condition and his needs. The Association would, therefore, plead with the committee and Congress to take all appropriate actions in this session of the Congress to relate titles 18 and 19 to each other. Then, Mr. Chairman, in connection with medicare, itself, we make a number of points in the next paragraph.

The Association notes with concern the omission of certain provisions in the 1969 amendments to which it has spoken with a measure of urgency on repeated occasions. First, in certain instances the extended care facility is adequately equipped and staffed to provide necessary care, the requirement that the patient spend an initial 3 days in the hospital could be safely eliminated. This could be done, for example, under certain conditions in stroke cases or in cases of simple fractures.

On occasion, nonprofit ECF's have had especially to urge doctors in cases of this nature to send patients to hospitals, simply so that beneficiaries and/or their families might enjoy title 18 benefits. There are instances of physicians reluctantly hospitalizing these patients against their better medical judgment, but pressured into this action by financial realities.

The Association will be happy to offer language eliminating the 3-day hospital stay and thus reducing medicare costs within a framework which is safe for the patient and consistent with good medical practice.

Secondly, the Association notes that no provision has been made to deal with the spell-of-illness problem, which continues to plague those older people unfortunate enough to suffer major illnesses while living in homes for the aging and nursing facilities.

The Association has recommended in the past that the establishment of a certain number of medicare benefits days on a calendar-year basis is the only equitable solution to this problem. It has further suggested and continues to suggest that costs will be reduced in the medicare program if an arrangement is legislatively created to permit flexibility with respect to hospital and ECF days. The Association suggests that one hospital day be the equivalent of 2 ECF days and that the doctor be permitted to interchange these days as the needs of the patient demand this change.

The Association also notes with the deepest concern the testimony of Mary Adelaide Mendelson, planning consultant, nursing homes, the Welfare Federation of Cleveland. While the Association itself has not had an opportunity to verify the statements made by Mary Mendelson, it does believe that certain of the conclusions arrived at

in her testimony would, under any circumstances, be sound practice: (1) an aggressive HEW role in protecting Federal funds; (2) Federal audits of long-term care facilities on a random basis; (3) the disallowing of claims submitted after a defined period of time; (4) tighter surveillance policies to avoid the abuse of duplicate payments.

Moreover, the recommendation to eliminate direct money payments to institutionalized aging and use vendor payments should be thoroughly explored as well as a method to eliminate fraud in connection with accepting Federal moneys, and you may remember that the suggestion was made that this kind of fraud be made an indictable crime. The Association believes that the use of these techniques might be helpful in reducing the costs of the present medicare and medicaid programs.

The Association would also call attention to its statement on accreditation, which elaborates the central principle that accreditation, by the Joint Commission on the Accreditation of Hospitals, of an extended care facility should be recognized as the equivalent of certification by medicare. It believes that such a Federal support of voluntarism will help keep alive the voluntary principle in American society and, concomitant with this, will encourage all who support the health system with their contributions, which still do accrue to the health system as a result of voluntarism and do reduce the need of Federal funds in health care. The Association believes that anything which can be done to undergird voluntarism is of prime significance to the health system and to American society, both from a moral and a practical, financial point of view. It also points out that recognition of a voluntary system of accreditation would reduce substantially the costs of carrying out Government surveys of facilities.

In its statement on area-wide planning the Association adopted and still adheres to the principle of area-wide planning on a voluntary basis. The principles adopted by the Association include these: that planning be restricted to the capacity of institutions, that is the bed capacity, that long term care institutions accept the concept of the mandatory funding of depreciation in their own facilities and reject the mandatory funding of depreciation in a community fund of pooled moneys.

The association, however, finds several difficulties with section 2 of the Health Cost Effectiveness Amendments of 1969. The mechanisms for the overall planning of health facilities have, to the best of its knowledge, for the most part not started to function, and it seems difficult to suppose that the 1969 amendment, if passed, can be related, within the next year or two, to any concrete overall area planning. This is a pragmatic concern, not a concern in theory with what the section contains. Moreover, the language of the section does not clearly indicate any limits to the penalties an institution may suffer under it. In the opinion of the association, the language of this section needs additional study.

The association would raise one question concerning section 3 of the amendments. Since the planning process will encompass facilities other than extended care facilities, the question arises: does the language of the section, and should it, limit fiscal reporting only to ECF's and not include all long-term care agencies?

While the provisions of section 4, dealing with experiments in the field of health care, would seem to be so qualified as to protect institutions and prevent unfair and detrimental experimenting with them, the association expresses a general caution with respect to this section and urges consideration of its cancellation or of its modification.

First, the association believes that the Secretary could find sufficient number of facilities in a geographical area to conduct valid experiments on a voluntary basis. In spite of the cautious language of this section, moreover, the association believes that there may be occasions when experimentation would be to the fiscal detriment of facilities. It further notes that no provision exists for canceling any experiment which obviously is creating financial difficulties for facilities involved in it.

The association endorses the provisions of section 5, dealing with abuses of the medicare program and again calls attention to the recommendations made by Mary Mendelson of Cleveland. Section 8, in the opinion of the association, is commendable.

Before concluding its testimony the association wants to take this opportunity to incorporate into the record its statement on fragmentation of care and notes that the warnings issued in this statement of October 17, 1968, have not only been proven to have been sound warnings, but that conditions in the Nation may have become far worse than those envisioned by the statement.

This document on fragmentation of care incorporates principles for which nonprofit homes for the aging have traditionally stood on the American scene: the continuity of care for the older person and comprehensive care for him. The document speaks of the trauma of moving older people from facility to facility or from one section of a facility to another, and speaks of the security older people find in permanently residing in the same rooms as their homes to which all necessary services are brought.

It further points out that compartmentalization of services, if literally and fully carried out, will result in increased capital and operating costs and that the current nursing patterns in many excellent institutions, in which patients needing varying degrees of services are grouped around a nursing station, remains the most efficient pattern known.

While the association created its document on fragmentation in its concern over the creation of intermediate care facilities, these principles and the additional principle it enunciated in the document, that the cost of providing protective and preventive medical and nursing services to patients who might qualify for the so-called intermediate care facilities" would be negligible, and that these services would tend to reduce the cost of health care in the State remain true principles. At considerable length the document expresses the association's concrete concern with costs and offers detailed evidence of this.

This statement on fragmentation of care worried over the possibility that the creation of the intermediate care facility might lead to a regression in the care of the aging in many States. May I briefly describe what has taken place in Wisconsin, which may be typical of other States, during the last memorable year?

If the Congress is concerned with the care provided the aging, it will be deeply interested in the Wisconsin facts. At the time that this

document was created, the facility I administer in suburban Milwaukee was receiving payments for four (4) classes of care: extended care, and skilled nursing care for people requiring a minimum, moderate, or maximum amount of this care.

Today, in this facility a patient can be classified as needing any one of 12 different levels of care. How the distinction between these 12 levels of care is finally made is difficult to grasp. All homes in Wisconsin which do not qualify as skilled nursing care facilities under title 19, with its provision for RN and/or LPN coverage around the clock, may qualify as skilled nursing homes, eligible for negotiated O.A.A. payments, if they furnish 40 hours of RN coverage weekly. Moreover, homes may qualify as limited care nursing homes if they furnish 40 hours of LPN coverage weekly. With no professional nursing coverage they may qualify as personal care homes.

In both the last categories payment for care is also by negotiated OAA fees. The OAA skilled and limited-care nursing facilities both are paid for patients according to whether or not they need minimum, moderate, or maximum care. Personal-care homes qualify for minimum and moderate care payments. Other similar ramifications of such systems in other States were opposed by association members over the last several years and still are opposed by the association as tending to provide inferior care to people who are in need of good care, as unnecessarily complex and arbitrary, and as not achieving the goals of fiscal prudence and efficiency they were intended to achieve.

In order to establish a system which provides adequate care to older people at minimum cost the association strongly recommends, therefore, that the necessary steps be taken to eliminate this and other costly machineries created by Government and that categories of care in long-term care institutions be limited to residential, skilled, nursing, (in various degrees), and the intensive care of an extended care facility. The Nation has already regressed further in the case of its aging than it should have.

Mr. Chairman and members of the committee, thank you for this opportunity to present to you the deep and abiding concerns of the American Association of Homes for the Aging. I know I need not plead with you on behalf of the hundreds of thousands of older people in facilities across the country to give your most serious consideration to the concerns the association has expressed today.

You are already committed to do that. I want to thank you.

Mr. BURKE. Do your associates wish to testify?

Mr. MUNNS. Mr. Chairman, I have a few brief comments to make regarding Mr. Eggers' remarks.

We appreciate this opportunity to testify and would like to state that it is our judgment that material changes being proposed need the complete understanding and approval of the public and providers of service as well as Government in order to assure their efficient and effective implementation, and wondered if your committee might wish to consider taking our hearings on the road in order that broader views might be heard across the country.

At this time of renewed concern, too, over the problems of poverty we recognize the important role of social security as a bulwark against poverty for the elderly. It is important, too, because this income results from some previous employment and is theirs as a right.

This right is an outstanding factor in fostering and providing the dignity of these senior citizens and in providing for some measure of free choice in directing their lives. Therefore, our association agrees that the social security benefits should not only be raised as proposed in H.R. 14080 but by a rate which is perhaps greater than that proposed.

This would enable your elderly citizens to afford at least a minimum of a standard of living.

We wonder if, in developing a method of meeting increased costs under these proposals, we could think of experimentation or the possibility of a change in social security arrangements so that Government could enter social security as a third contributing party in the program.

In addition to broadening the wage base and/or changing the rate of tax, it may be possible to improve the funds available for social security by having in addition to employer and employee contribution a Federal contribution from general revenues.

As to the welfare provisions of H.R. 13173, this makes a real beginning toward needed reforms in our welfare system. As a national organization we have seen the problems, even the degradation caused by inadequate minimum levels of income available to our elderly citizens, and we would enjoy seeing an improvement in this national level.

We could only add that it is our real wish and prayer that this could happen since it might provide the elderly a greater opportunity of free choice and permit them, for example, to remain out of more costly custodial settings for a longer period of time, living with relatives or friends.

We do note, however, that when these elderly can no longer survive without some essential services, usually involving an increased need for health care, our member homes, the nonprofit voluntary and church-sponsored homes in the United States stand ready to provide a choice of facilities where these needs can be met in an atmosphere of respect for their situation, the social and health needs fully met and in accordance with the appropriate safety and sanitary regulations.

In this regard, we commend the community which has provided through government the benefits of intermedial care, medicare, and medicaid to the elderly.

We support the extension of medicare to persons receiving aid to the disabled as well as to others who are social service, social insurance beneficiaries, such as those electing social security at age 62.

We deplore interpretations, some State and some Federal, of medicare and medicaid requirements which, while intended to limit costs, effectively remove some elderly from intended benefits of these acts, and we would include herein adequate reimbursement in some States and problems as the Reverend Eggers has explained as to definitions such as spell of illness.

We applaud those interpretations of medicare and medicaid requirements which intended to limit costs to permit and provide needed services for the elderly as benefits of this act and encourage their implementation, for example, as the Reverend Eggers has spelled out in his remarks by the exchange of hospital and ECF days.

Thank you for permitting us to present our thoughts to you.

MR. DAVIS. I am not going to make any statement now, Mr. Chairman.

MR. BURKE. Does that complete your testimony? Have you submitted all of your statement here?

MR. DAVIS. Yes; we have submitted not only the statement, but the supporting documents which the Reverend Eggers referred to earlier.

MR. BURKE. Would you like to have those included in the record?

MR. DAVIS. I think it would be helpful.

MR. BURKE. Without objection, they will be included and on behalf of the committee we want to thank the panel for its excellent testimony here.

MR. DAVIS. Thank you.

(The information follows:)

STATEMENT ON FRAGMENTATION OF CARE

The American Association of Homes for the Aging has, since its formation, consistently expressed the central concern of its members for the best possible care of aging people living, for one reason or another, in a long-term care facility, whether in its residential with personal care or nursing care portions.

The very heart of this concern lies in the Association's belief that each person is an individual, that however much his needs have in common with the needs of others, each individual has needs peculiar to himself, that communal living in facilities for the aging, while satisfactorily meeting many of his needs in the most inexpensive way, tends to curtail the fulfillment of some of the desires he is capable of fulfilling, in spite of any limitations he may have, and that facilities for the aging must do all within their power to respect the unique identity of each person, to help him fulfill himself, and to grant him the maximum freedom and security possible to him in such a communal setting.

The Association's deep concern about the identity of the individual traces back to many historical and ethical sources. Most nonprofit homes have arisen out of the desire of Christians and Jews to care for their own and other aging people. Deeply motivated by their faiths to their historic deeds for the aging in need, they have expressed their common feelings about the worth of each person in the architecture, programs, and care provided by their facilities. Other non-profit homes, created by civic-minded community groups or by governmental jurisdictions, have contained many board or corporate members with these same motivations or with similar liberal and humanistic stances. All of these facilities have expressed also the great national tradition, inherited from our American forefathers, concerning the freedom and rights of Americans, a tradition restated repeatedly in recent years by American leaders as they have discussed the issues of race, poverty, slums, education, and other social problems today troubling our nation.

Already at its inception the members of the American Association of Homes for the Aging expressed their great concern about this essential matter by speaking of "continuity of care and comprehensive care" for the institutionalized aging of America. By continuity of care the Association then meant and means today that the aging person who lives in a long-term care facility should there receive continuous care till he dies and should not be forced to shift from facility to facility or from room to room within a facility to obtain the type of care appropriate to him. By comprehensive care the Association then meant and means today that the facility should regard the aging person in his totality as a man and appropriately provide him with all aspects of care, including the meeting of his social, emotional, religious, and other needs as well as his need for physical care.

The Association and its members well know from personal experience and also from scientific studies the traumatic experience which entrance into a facility for the aging means for most individuals. They also know the humane and sometimes life-preserving values of providing the individual resident with a room which is and remains, till he dies, literally his home, in contrast with the minimal importance of this aspect of the environment to patients in acute hospitals. Homes for the aging, moreover, are more than communal centers for the short-term treatment of specific diseases: they must deal with the total patient and the many environmental factors (called by our Association "the social components of care")

so important to his care and progress medically, socially, and emotionally, and so damaging to him if these factors are neglected.

Out of their vast experience and supported by the findings of sociological and other studies, the Association and its members have, therefore, evolved, long before recent federal reimbursement programs were enacted, two cardinal and practical principles in serving the aging in their facilities.

The first has historically been: to provide for their residents as permanent a home as possible, in the sense of providing a room with which they can identify themselves the remainder of their lives. In many homes this has meant the assignment of a room to a new resident with the planned provision of all appropriate services, even the most intensive nursing services, to him in this room. In other homes this has meant the initial assignment of a residential room to a person needing few, if any, nursing services, and his subsequent transfer to the nursing area of the facility, when and if this became necessary. Generally, no more than one room transfer has occurred, and this has been only to the home's nursing area.

The second cardinal and practical principle has been this: the continuous and appropriate provision of all services to all residents and patients. The Association knows that the major variable of financial consequence in a facility for the aging is the degree and extent of nursing care which the aging person needs. All other services ("the social components of care") are necessary to the well-being of all the aging within the facility.

At the present time facilities for the aging are threatened by a compartmentalization of categories of care, the result of a number of legislative actions, which tends to undermine this historical and humane treatment of the aging. These legislative actions and their interpretations tend to fragment facilities into four sections: a section providing intensive or ECF care, a section providing skilled nursing care, a section providing intermediate care, and a section providing residential care. For a number of major reasons the Association and its members know that this legislation will have unfortunate effects on the institutionalized care of aging people.

Not only will this legislation require an initial massive movement of individuals to areas of the building designated for their level of care, but in his stay in a facility for the aging, the individual will have to be moved from section to section as the degree of his need for nursing care changes. While some aging will undoubtedly follow a pattern of progressive debility and increasing need of nursing care, requiring two or three moves, many others will have to be moved from one section to another, up and down the scale of nursing care, as their needs change. The traumatic effects of this movement may be considerable. The security of identifying with a single room in the facility or in its nursing care section will be destroyed for many people.

If these fragmenting laws, moreover, are to be followed literally, they will considerably increase the capital costs of long-term care facilities. Sufficient flexibility within a facility will be needed for it to conform to the laws, and this flexibility will require that a percentage of beds will have to be kept available in each area to permit the cruel and inappropriate movement of residents and patients. Some members of the Association have estimated, on the basis of their experience, that they will have to decrease their current census by 10% in order to conform with these provisions.

As a result of this fragmentation of a facility into distinct parts, operating costs will also of necessity rise. Regardless of their census at any given time, these distinct areas will have to remain fully staffed to protect the facility against the contingency of a rapid change in census. At present nearly all facilities follow—and it is our philosophy that they should follow—the same basic nursing care pattern: each of their nursing stations serves, as hospitals also essentially do, patients needing a variety of degrees of care, ranging from intensive to intermediate. A nursing station serving 35 patients might, for example, have 4 intensive care patients, 10 needing skilled nursing care, and some 20 receiving intermediate care.

This has historically provided the most efficient operation in long-term care facilities and current experience and studies indicate that there is no reason to believe that a higher level of efficiency can be achieved under any other system especially in long-term care facilities, which have staffing and other problems peculiar to themselves, because of the very nature of the services they render.

Individuals concerned with the question of cost have stated that the intermediate care patient, as defined by the regulations, does not need the services of a RN and/or LPN. It is the position of the Association and its members that in

the nursing units they now manage the type of care received by intermediate care patients is provided by nurses' aides, that the provision of this service under the direction of licensed personnel is invaluable in protecting these patients, and that the preventative health services which these licensed personnel provide significantly reduces the cost of health care to older people. The daily cost of having these protecting and preventative services available is so minimal and the values of these services so great that the financial and other benefits derived from this pattern of care outweigh its costs. Moreover, the permanent disruption of this pattern of nursing care, the Association contends, may well prove financially detrimental and raise the costs of all health care programs for the aging.

In addition, the interpretation of the present legislation in this area by the several states may lead both to a regression in institutional care for the aging and to possibly harmful rigidities. States may see the provisions of the intermediate care legislation as an opportunity to curtail their expenditures for the aging without recognizing the significant fact that they may tend at the same time to lower the level of care which they have already achieved.

It may be noteworthy that one state, in its initial preparation to implement the intermediate care program, informed the administrators of non-profit homes, willing to accept even minimal reimbursement for intermediate care persons and to finance any costs above this minimal reimbursement out of charitable funds in order to avoid the fragmentation of their homes, that unless their homes created intermediate care sections, no reimbursement for intermediate care patients would be allowed them. These non-profit religious and community homes have stated that discrimination against them exists in their states.

In view of the patterns of care for the aging in some states and current conditions in general, the Association and its members feel deeply anxious about the impact of intermediate care and other comparable legislation in the 50 states.

It seems obvious that the intermediate care legislation was passed by Congress in an effort to control the burgeoning costs of providing health care for the aging. Moreover, this and similar measures, Titles 18 and 19, seek to allocate costs, as precisely as possible, for the various levels of resident and patient care.

The Association appreciates the intent of Congress, and has and will continue fully to cooperate with Congress and the Department of Health, Education, and Welfare, in keeping health care costs to a minimum. Perhaps as no other group in the nation, the members of the Association are acutely conscious of health care costs, for it is they who must translate these costs into charges for hundreds of thousands of older people in their facilities, people on fixed incomes and with limited reserves. They know that any necessary increases in charges to these aging people represents a slow erosion of their life savings and their hopes of fiscal security and independence. Many older people are acutely conscious of this and frequently express their fiscal concerns to administrators and boards of non-profit facilities.

No assurance that the resources of the federal reimbursement programs are at their disposal fully satisfies these aging. Many members of the Association, therefore, watch with anxiety the developing wage and salary patterns of hospitals, which they must follow in order to compete for personnel, knowing that the patients and residents of their facilities cannot cushion the fiscal blows of spiraling costs by small monthly increases in health insurance charges. The residents and patients of their homes must immediately bear the full brunt of these rising costs out of limited resources.

Nor do these rising costs affect only the residents and patients of these homes; they often gravely affect the financial structure of the homes themselves. Many non-profit homes remain dependent on charitable contributions to support them in their deficit financing. The consultant to one church group of some 90 homes for the aging, for example, is acutely conscious of the fact that during the five years before Medicare, these homes experienced a 6-8% rise in costs and that during the two years since the Medicare legislation became effective, the average annual costs in these homes have risen more than 11% annually.

Evidence of their fiscal concerns presents itself in yet another aspect of their dedicated work for the aging. Because these non-profit homes, their boards, and administrators are cost-conscious, a growing number of them have started (or have begun to experiment with) non-institutional programs for the aging in order to reduce the expenditures of the community on behalf of older people, while providing them with the service they need.

For these reasons the members of the Association generally have maintained a highly conservative financial approach in the operation of their facilities.

Moreover, never before in their history have they had to allocate costs with the precision with which the Medicare program had made mandatory and other legislation may also require. They have, however, under a variety of systems—some created by themselves on their own initiative, others created by the states (in some cases reasonable and not requiring extensive paperwork)—allocated costs with reasonable fairness to individuals receiving different degrees of nursing care. They have done this in order to distribute costs as justly as they can among the aging they serve as well as to preserve their unique and valuable approach to serving the older person in the security of a “home” that is personally and individually his.

It, therefore, seems to the Association and its members that some fiscal system, which will be simple and fair, can be created reasonably to determine the cost of care for individuals for whom federal reimbursement is available. The members of the Association are at all times willing to provide the proper authorities with full fiscal information, so that appropriate formulas, not requiring large expenditures of time and paperwork, can be mutually and satisfactorily worked out with them. Moreover, the Association again offers to appropriate state and federal personnel the services of its accountants to help establish these formulas.

The Association furthermore believes that the fiscal and other principles, which it has enunciated in this document, have an equally valid application to proprietary homes. It is persuaded, for example, that equity requires full fiscal disclosure on the part of all providers of care receiving federal matching funds in the Title XIX and the proposed intermediate care programs. While it can appreciate the need of proprietary homes for a reasonable return on their investments, it does not understand the reasoning behind the omission of federal guidelines and fiscal disclosure (as in Title XVIII) in the Title XIX and intermediate care programs. It believes that these omissions invite inequities in reimbursement.

In conclusion, it is the fear of the Association and its members that the present and proposed systems, dominated as they are by reimbursement mechanisms, will not only erode a way of life for the aging which has stood the test of history for its humanity, but will immeasurably increase the costs of health care in the nation.

With the resources and ingenuity of the American people a more humane and less costly system of providing health care to the aging can be devised.

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(NOTE: Full documentation of the statements in this position paper has been prepared and will be available from the New York office.)

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AMERICAN ASSOCIATION OF HOMES FOR THE AGING, OCTOBER 17, 1968

STATEMENT ON ACCREDITATION

Voluntarism has historically been prized in America. In special ways the state has shown how much it cherishes and wants to further the voluntary banding together of civic-minded and charitably-minded individuals into associations which in one way or another promote the common welfare of the American society. The state has encouraged the self-discipline involved in America's voluntary associations, appreciated the initiative, patriotism, and social concerns of its citizens in their work for the common good. The state has seen in these voluntary efforts a strengthening of both personal ethics and the ethical fabric of American democracy. To that end the state has customarily granted non-profit,

voluntary associations tax exemptions both in the area of corporate and property tax and noted from time to time, with special recognition the success of various voluntary associations.

Voluntary, non-profit efforts, apart from the work of churches, to promote their beliefs and ethical standards, have broadly tended to be either charitable or educational. In more recent years, as professionalism has grown, some voluntary efforts have been channeled into the area of professional self-discipline and standard-setting. This development has occurred, for example, in the field of education and in the field of medicine.

As hospitals more and more became community centers for medical practice, concerned groups created the Joint Commission on Accreditation of Hospitals, which has for some decades been the nation's voluntary agency in establishing hospital standards and approving hospitals which have met these standards.

The rapid expansion of long-term care facilities, which began in the forties, led to efforts to create a similar voluntary standard-setting and approval mechanism in the early sixties. A few years ago, as a result, the Joint Commission on Accreditation of Hospitals became the voluntary accreditation body for long-term care facilities in the nation.

The history of the American Association of Homes for the Aging in standard-setting, a matter of record, is significant history in this connection and in general. Immediately after the Association's formation at Arden House, New York, in November, 1961, it was prepared to join the members of the Joint Commission on Accreditation of Hospitals, the American Hospital Association, the American Medical Association, the College of Surgeons, and the College of Physicians, in their common concern about ethics and standards in the field of long-term care. At the same time, it also expressed its willingness to cooperate with the American Nursing Home Association in this vital effort.

The Association took this high ethical stand and engaged in these activities on behalf of standards, it should be noted, at least four years before the Medicare legislation was enacted and has continued its support of excellence of care ever since then, even though the accreditation of long-term care facilities has not yet been recognized as the equivalent of Medicare certification.

Deeply concerned about standards of care in long-term care facilities, the Association, shortly after the JCAH originally decided not to engage in the accreditation of long-term care facilities, called and conducted the first meeting of concerned national professional and institutional associations, in an effort to create a national accreditation body for all long-term care facilities. It continued its efforts through a series of major national meetings and various committee and other meetings until became evident to all participants that the Association's original goal would not, at that time, be achieved.

At the conclusion of this effort the Association joined with the American Hospital Association and a number of appropriate national professional associations to create the approval program of the Hospital Association. Through this program standards were created and many hundreds of long-term care facilities surveyed, approved, granted limited approval or not approved. The Association vigorously supported this program and created a special document, *The Social Components of Care*, to help the Committee on Approval of the American Hospital Association identify the non-medical aspects of long-term care and create standards for them.

When the Joint Commission on Accreditation of Hospitals later became the voluntary accreditation body for long-term care facilities in the nation, the Association welcomed this development, accepted a seat on the Commission, has since supported the Commission financially, by representation on the Commission, by its counsel and advice concerning the long-term care accreditation program of the Commission, by its attendance at all appropriate committee meetings of the Commission, and by publicizing to its members the values of accreditation and encouraging them to seek JCAH recognition and approval.

Also in the long-term care field, then, the Joint Commission, whose accreditation program for hospitals has been recognized by Congress, exhibits all the values of voluntary organizations. It is voluntary, it promotes the common welfare of our American society in a significant part of the health care field, it fosters self-discipline and furthers ethical patterns of care for patients, it is sponsored by civic-minded and knowledgeable associations and their members, and it does, in its area of competence, strengthen the fabric of democracy.

There is no question, then, to speak again especially of the concerns of the American Association of Homes for the Aging and its members, that this Asso-

ciation fully believes in voluntary self-discipline and the application of high ethical standards to all institutions in the nation providing long-term care. While the Association recognizes that at the time of the passage of the Medicare legislation, the Joint Commission's accreditation program for long-term care facilities was still relatively new and had not been subjected to the test of decades (as had the hospital accreditation program), and that some mechanism of necessity, therefore, had to be created by legislation to certify that Extended Care Facilities did in fact meet appropriate standards in providing care, the Association now believes that the Department of Health, Education, and Welfare can appropriately and safely recognize accreditation by the Joint Commission as the equivalent of certification for Extended Care Facilities.

This acceptance of the JCAH long-term care accreditation program will greatly strengthen the health field, in keeping with historic American principles, by recognizing the values of voluntarism and the mature manner in which a considerable segment of the long-term care field continues to discipline itself.

Other important factors indicate that such an official recognition of accreditation would not only be invaluable to the government, the providers themselves, and the hundreds of thousands of patients they serve, but also appropriate at this time.

While some differences of language remain between the standards of accreditation and certification, these are minimal, largely semantic, and to be expected when two different groups search for appropriate language in the creation of standards. The significant point about these two sets of standards is their essential agreement in all matters of genuine concern.

The Association and its members recognize that one major difference does exist between the governmental and the voluntary approval programs: the governmental program is based on an annual survey; the voluntary program, on a survey at three-year intervals. The Association believes that a reasonable resolution of this difference, acceptable to nonprofit homes, would be the survey of long-term care facilities at two-year intervals, and urges the Department of Health, Education, and Welfare earnestly to consider this resolution of the only substantial difference between the two approval programs.

Secondly, the recognition of accreditation as the equivalent of certification would provide a single, independent national body which can more consistently and uniformly interpret and apply standards than can be achieved by the inevitably varying interpretations of these standards by fifty state agencies. This recognition may also help eliminate any question of possible political influence in the application of the standards.

Thirdly, as a growing number of long-term care institutions express their convictions about the values of such a viable voluntary system by requesting Joint Commission approval and as various third-party payors require the approval of providers by the Joint Commission as a qualification for reimbursement, the general endorsement of the Joint Commission's long-term care accreditation program has apparently grown to the point at which the continued non-recognition of this program by the Department of Health, Education, and Welfare can become a matter of deep concern to many knowledgeable people and to the public.

Moreover, as the expanding health and welfare programs of the nation require new and additional federal funding, the recognition of accreditation as the equivalent of certification, since JCAH surveys are paid for by the facilities seeking accreditation, could result in a substantial economy in federal expenditures.

For these reasons and, especially to conserve some of the values which have made America the great nation it is, the Association most strongly urges the Secretary of HEW to grant, at this time, full recognition to the Joint Commission's program for the accreditation of long-term care facilities as the equivalent of certification.

AMERICAN ASSOCIATION OF HOMES FOR THE AGING, OCTOBER 17, 1968

AREAWIDE PLANNING

(Draft Statement—Principles Adopted by the full Medicare Committee)

The American Association of Homes for the Aging recognizes the need and desirability of area-wide and state-wide planning of health services and health care institutions. Within the framework of community planning bodies, the

Association, however, also believes that each facility should enjoy the maximum flexibility and independence in its capital planning and decisions, which is possible.

Since P.L. 89-749, as amended, provides for state-wide and area-wide health planning as well as for the financing of these planning bodies on a matching basis, the Association strongly urges that state and local groups make every effort possible to obtain adequate representation of homes for the aging at all planning levels.

The Association further urges that representatives of non-profit homes for the aging uphold the Association's position that the work of planning groups embrace the voluntary planning of health facilities so that community needs are met through the creation of new facilities and that further details of the creation or expansion of these facilities be matters of the facilities' decision.

Moreover, the Association supports the position of mandatory funding of depreciation by the facility and believes that the mandatory funding of these monies in a community fund of pooled monies, under any form of trusteeship, is unwise.

The Association also believes that at this time definitions and criteria concerning the scope of the planning agencies' functions need to be established in greater detail.

It is the position of the Association, moreover, that criteria, by which the work of planning agencies can be adequately evaluated, also need to be established and that the establishment of these criteria are a matter of critical importance as homes for the aging accept the concept of voluntary planning.

The Association believes that the cooperation of all homes in this community planning process is vital and essential to maintain the strength of the voluntary, non-profit, health care facilities of our nation and provide all community members involved in the planning process with information, insights, and guidance in a sector of the health field which heretofore has not been a concern of most community health planning groups.

Full participation in voluntary planning, the Association believes, must be carried out in a mature and responsible manner by all non-profit homes for the aging. Without this kind of participation by all sectors of the health field, the possibility of full government control of all health care planning may be an option which will be exercised by the next Congress.

The Association now has in preparation two statements which may be of considerable value to non-profit homes: a statement on the significant community services which a home may provide the area it serves and an up-dated rationale for voluntary, non-profit homes. The need for these statements became evident to the Medicare Committee in its discussions on area-wide planning and both of these statements are directly as well as indirectly pertinent to the planning issues. The Committee hopes that these statements will be available to AAHA's membership within the next several months.

AMERICAN ASSOCIATION OF HOMES FOR THE AGING, OCTOBER 17, 1968

UNIFICATION OF CERTAIN ASPECTS OF LONG-TERM HEALTH CARE

Goal.—To achieve a single reimbursement formula, a single annual survey, and a single annual audit for long-term care facilities.

Proposal.—To obtain recognition for a single, complete reimbursement formula, meeting the financial needs of homes for the aging for all categories of care, appropriately modified for each category; to achieve recognition of the qualifications of a home for the aging by meeting standards for all levels of care through a single survey by the Joint Commission on Accreditation of Hospitals; and to achieve financial review and financial adjustments by third-party payors, at the close of a fiscal year, by a single audit made by an independent CPA.

Advantages.—A single reimbursement formula would achieve the efficiency gained by national uniformity, both as far as facilities and third-party payors are concerned, and these advantages include adequate income for providers of care, a stable base from which they are able to do financial planning, and the ability of the reimbursement mechanisms to handle the reimbursement problem in a rational manner. A single survey recognized by state and federal authorities, for all levels of care within a facility, would eliminate duplication of surveys, reduce costs on the part of standard-setting bodies, and also have the same

beneficial effects for providers of care. A single audit would achieve the same efficiency in financial matters which would be achieved by the single survey.

The Medicare Committee recognizes the breadth and almost visionary aspects of this proposal. It believes, however, in its validity.

At the federal level the Association has already indicated to appropriate people the values of this proposal.

The Committee believes that the Association should continue to press for this goal on this level and strongly urges the state associations also to press for it on the state level. With united and continuing advocacy of this portion at all levels of government, it should be possible to make progress toward reaching this goal within the next years.

Mr. BURKE. Our next witness is Mr. Clinton R. Miller.

You may proceed. We welcome you to the committee. You are our last witness. So just take your time.

STATEMENT OF CLINTON R. MILLER, VICE PRESIDENT, NATIONAL HEALTH FEDERATION; AND CHARLES ORLANDO PRATT, WASHINGTON GENERAL COUNSEL

Mr. MILLER. We will be brief, Mr. Chairman.

I am Clinton R. Miller, the vice president, and the legislative advocate of the National Health Federation. With me, to my left, is Charles Orlando Pratt, who is Washington general counsel of the National Health Federation. He will present our prepared statement.

Mr. Chairman, the National Health Federation is a national organization of concerned and aware taxpaying consumers of health products and services who, among other interests, are opposed to a continuing medical monopoly of medicare.

We believe it is time medicare received an adjustment to include chiropractic.

In this regard we would like to state that we support 100 percent the testimony of the two organizations which appeared earlier today, the American Chiropractic Association and the International Chiropractic Association, and endorse the testimony that they gave this committee.

I respectfully request, to save the time of the committee, that the short critical report that I prepared for the February issue of the National Health Federation Bulletin which is entitled "How to Medically Stack an Ad Hoc Study Committee and Thwart the Intent of Congress," be included in the record.

This, Mr. Chairman, is the 2-page article on pages 15 and 16 in the bulletin which you have there.

Mr. BURKE. Without objection, it will be included.

Mr. MILLER. Thank you.

Mr. BURKE. Do you want that at the completion of your statement?

Mr. MILLER. If you would, please.

Mr. BURKE. It will appear at the end of your statement.

Mr. MILLER. I also respectfully request that you include in the record the enclosed list of 64 U.S. Representatives who have introduced similar or identical bills to include chiropractic in medicare in this Congress as of today, November 3.

Mr. BURKE. Do you have that list?

Mr. MILLER. Yes.

Mr. BURKE. Without objection, it will be included.

Will you give that to the reporter, please, sir.

Mr. MILLER. I have given it to the reporter.

Mr. BURKE. Thank you.

(The information referred to follows:)

WASHINGTON REPORT—HOW TO MEDICALLY STACK AN AD HOC STUDY COMMITTEE
AND THWART THE INTENT OF CONGRESS

(Clinton R. Miller, NHF Legislative Advocate)

Early last year, Congress instructed the Department of Health, Education, and Welfare to make a study of the advisability of including other healing arts in Medicare. The report was to be ready for Congress when it started its present session. Congress intended, and took every reasonable precaution to insure that the committee which would make this study would be fairly representative of many points of view and would return to them an unbiased report to help them in drafting new legislation.

Congress wanted the report completed by January 1, 1969, and specifically instructed HEW to meet this deadline. Characteristically showing contempt for the Congressional target date, HEW didn't even appoint the committee until September, 1968, four months before the report was due. But the extent of HEW's arrogant disrespect of Congressional intent was not fully realized until we received a list of the "Ad Hoc Consultant Group Members."

"YOU'VE GOTTA BE KIDDING"

When I first looked over the list of the 22 members, I felt someone was "putting me on," as they say nowadays. I still find it hard to believe that anyone was serious in believing Congress would stand still for HEW's open insult to their intent that a FAIR committee be picked to study and report on the sensitive subject of fair representation of all licensed healing arts in Medicare.

Five medical doctors dominate the committee. There isn't a member of the 22-man committee who was selected to represent chiropractic, the second-largest healing art, the healing profession which generated the heat which caused Congress to ask for the study in the first place. If the AMA had picked the committee from Chicago (and we have little reason to believe they didn't), they couldn't have weighted it more heavily in favor of a continuing medical monopoly of Medicare.

But then, maybe I'm overly sensitive about this matter of fair representation on committees. I'll list the 22 members and their affiliations, if known, at this point in my report. If you think I have been prematurely harsh in my judgment, write and tell me. If not, you had better write your Representative and tell him what you feel the chances are of an unbiased report coming from this kind of a committee.

The Ad Hoc Consultant Group members are :

1. Chairman: Mr. Frank Bane, Washington, D.C.
2. Mr. Nelson H. Cruikshank, Washington, DC.
3. Mr. Fred C. Diamond, President, Hillhaven, Inc, Tacoma, Washington.
4. Mr. Howard Ennes, Second Vice President and Director of Community Health Services of the Equitable Life Assurance Society of the U.S., New York.
5. A. R. Foley, M.D. Chairman, Department of Psychiatry, The Catholic Medical Center of Brooklyn and Queens, Inc, New York.
6. Mr. James M. C. Haughton, First Deputy Administrator, Health Services Administration, City of New York.
7. Mr. Teid T. Holmes, Administrator, North Carolina Baptist Hospital, North Carolina.
8. Jack Kleh, M.D., Washington, D.C.
9. Leslie Knott, M.D., Los Gatos, California.
10. Margaret D. Lewis, Director, Visiting Nurse Association, Denver, Colorado.
11. Darrel J. Mase Ph.D., Dean, College of Health Related Professions, University of Florida, Gainesville, Florida.
12. Nagi Saad, Ph.D., Department of Sociology, Ohio State University, Columbus, Ohio.
13. Senator Maurine B. Neuberger, Chairman, Citizens Advisory Council on Status of Woman, Department of Labor, Washington, D.C.
14. Mr. Walter Newburgher, President, Congress of Senior Citizens.
15. Mr. Sam Pollack, President, Meat Cutters District Union 427, AFL-CIO, Cleveland, Ohio.

16. Ernest W. Saward, M.D., Medical Director, Kaiser Foundation, Hospitals, Beth Kaiser Hospital, Portland, Oregon.

17. William Selden, Ph.D., Princeton, New Jersey.

18. William A. Spencer, M.D., Director, Texas Institute for Rehabilitation and Research, Houston, Texas.

19. William B. Strong, D.O., New York, N.Y.

20 Robert Westlake M.D., Syracuse, New York.

21. Sidney Silverman, D.D.S., Professor and Chairman, Department of Graduate and Postgraduate Prosthodontics, College of Dentistry, New York University, New York.

22. Floyd D. McNaughton, Arlington, Virginia.

I wish to emphasize that my criticism here is of the structure of the committee, not of any individual member (except, possibly, the chairman). But I wouldn't expect a group of Catholics to bring back an unbiased report about Protestants and vice versa. Nor would I expect the Republicans to make a fair, objective report about the Democrats. I certainly do not believe a medically-dominated committee structured like the above can bring back a report which will be seriously considered by Congress.

The president-elect of the American Medical Association, Dr. Gerald D. Dorfman, was quoted in the New York Post on November 7 as saying that "changes may be enacted by the new Congress in the Medicare program for the aged, including an expansion of qualified health providers to groups such as chiropractors. . . ."

Obviously, the president-elect of the AMA knows the temper of Congress, We think we do, too. And we don't think Congress will put up with this kind of shenanigans from HEW.

When you write your Congressman you may refer to this article in the February NHF Bulletin, a complimentary copy of which you have had sent to him. Every member of Congress receives an NHF Bulletin each month with your compliments. Insist that HEW balance this committee with chiropractors, naturopaths, etc. They probably won't have completed their report when you read this. So write immediately!

(65) CONGRESSMEN (62 REPRESENTATIVES AND 3 SENATORS) WHO HAVE COSPONSORED IDENTICAL OR SIMILAR BILLS TO H.R. 331 AND S. 746 TO INCLUDE CHIROPRACTIC IN MEDICARE AS OF OCTOBER 15, 1969

Alabama : 1. Andrews ; 2. Bevill ; 3. Nichols.

Alaska : 1. Pollock.

California : 1. Anderson ; 2. Brown ; 3. Hawkins ; 4. Leggett ; 5. Teague ; 6. McFall.

Florida : 1. Haley ; 2. Pepper.

Hawaii : 1. Mink.

Illinois : 1. Anderson ; 2. Annunzio ; 3. Collier ; 4. Findley ; 5. Gray ; 6. Kluczynski ; 7. Murphy ; 8. Pucinski ; 9. Shipley.

Indiana : 1. Adair ; 2. Hamilton ; 3. Jacobs.

Maryland : 1. Friedel ; 2. Garmatz ; 3. Fallon.

Massachusetts : 1. O'Neill.

Michigan : 1. Nedzi.

Minnesota : 1. Karth.

Missouri : 1. Randall.

Nebraska : 1. Denney.

New Jersey : 1. Daniels ; 2. Gallagher ; 3. Helstoski ; 4. Minish ; 5. Patten ; 6. Rodino ; 7. Widnall ; 8. Howard ; 9. Dwyer ; 10. Sandman.

New York : 1. Biaggi ; 2. Hanley ; 3. McKneally ; 4. Murphy ; 5. Podell ; 6. Scheuer.

Oregon : 1. Ullman.

Pennsylvania : 1. Clark ; 2. Vigorito.

Rhode Island : 1. St Germain.

South Carolina : 1. Dorn ; 2. McMillan.

South Dakota : 1. Berry.

Tennessee : 1. Duncan.

Texas : 1. Casey ; 2. Wright.

Washington : 1. Hicks.

West Virginia : 1. Hechler.

Wisconsin : 1. O'Konski.

Senator Metcalf (Mont.).

Senator Anderson (N. Mex.)

Senator Hartke (Ind.)

Mr. MILLER. Mr. Chairman, when costs increase outrageously in any area of the economy, the first possibility which should be considered is that a monopoly or a cartel is causing it.

If we only allowed General Motors to furnish the Government with vehicles, we would have outrageous increases in cost.

This is somewhat similar to what we have done in medicare with the American Medical Association, and it is time it stopped.

It is our understanding that in 1965 and in 1967 the Senate approved chiropractic in medicare, but the House Ways and Means Committee failed to approve it. I therefore at this time, before I turn over the microphone to our general counsel, wish to state very strongly and emphatically that we do sincerely urge this committee this year to favorably report an amendment to include chiropractic in medicare.

Mr. Pratt.

Mr. PRATT. Thank you very much, Mr. Chairman.

I will try to make my talk brief, and I have cut out any unnecessary statement that describes the work of the National Health Federation which is a nonstock, nonprofit organization primarily consumer health oriented to fight for the rights of people and the right to have any kind of health care without any particular emphasis on what the care is so long as it doesn't harm or hurt anybody else.

The federation urges Congress to amend the Social Security Act so that the citizens of the United States who use the care of doctors of chiropractic licensed in their States shall be entitled to all the benefits of the program of supplementary medical insurance for the aged.

The federation believes that Congress should not make any law which will abridge the privileges or immunities of citizens of the United States in health care, provided in the Constitution and the Bill of Rights.

The federation believes that Congress should not deprive any person of the liberty to choose his or her own kind of health care from, and by, a duly licensed doctor of chiropractic.

The federation believes that the citizens of the United States and the doctors of chiropractic, duly licensed by the State in which they practice, should not be denied by Congress the equal protection of the laws of the United States by denying them the benefits of the Social Security Act that is available to others.

The federation believes that the absence of a provision in the Social Security Act providing for payments for chiropractic services, under the program of supplementary medical insurance benefits for the aged, may, in truth and in fact, constitute an unconstitutional, and an unlawful abridgement of the privileges and immunities of citizens of the United States. Such denial does deprive the citizen of his property right and liberty to choose and use the healing arts care, which he believes is, or will be, most beneficial to him. Such denial does, indeed, deny the U.S. citizen the equal protection of the Federal health laws.

The federation believes that the freedom of choice in health care is an inalienable right, which is necessary to secure the blessings of liberty and to promote the general welfare in health matters.

The citizens who are patients of doctors of chiropractic, and the said doctors, are taxpaying citizens. Their taxes are used to pay for the health and medical care and facilities under the Social Security Act. The use of this health care and of these facilities is denied the patients

of the doctors of chiropractic; and thereby, their rights and privileges are denied.

The medical and allied professions, for whose services Congress has provided payment under the program of supplementary medical insurance benefits for the aged, may not be able to do the whole job of protecting the health and welfare of the U.S. citizens, because millions of Americans do not use or want drugs unless required by law, and I mean in connection with contagious diseases, and immunization, and so forth.

Millions of Americans are justifiably afraid to use the powerful drugs, antibiotics and medicines on the market today, because of the repeated public revelation by the Government, the press, radio and television, that such products have dangerous, serious and sometimes deadly side effects.

The other day the Washington Star reported that 640 food additives have not been approved as being safe or efficacious. Yet the definition of a food additive is any additive used in food which is not recognized as safe, and we believe something should be done about it and people, if they want to, should have the care of doctors who do not use drugs or medicines or foods that do have additives.

These citizens, therefore, want to have available to them the professional advice and care of licensed doctors engaged in the healing arts professions, who do not recommend or use in their practice such products.

Congress should do justice to all U.S. citizens by providing for the use of Federal tax revenues, under the provisions of the Social Security Act, to pay for the health services of patients of doctors of chiropractic duly licensed under State law.

I am emphasizing duly licensed chiropractors under State law because in many States there are chiropractors practicing who do not have a license, and in Louisiana they can't get a license and in Mississippi they can't get a license. However, in the State of Mississippi they practice based on the decision of the Supreme Court of Mississippi which permits them to practice in a sense by interpretation.

Patients of doctors of chiropractic should have the same and equal right to have Federal assistance in paying their health bills as do the patients of the other healing arts professions. These citizens should not be deprived of Federal assistance.

American citizens should not be compelled, directly or indirectly, to be cared for, or treated, according to a majority opinion on health care.

America has grown strong by protecting minority rights against the overwhelming power and influence of the majority. This principle applies as much today in the need to protect the minority rights of the patients of the chiropractic doctor as it applies to protect the minority rights in religious or civil rights fields.

Congress should do no less than to protect the minority privileges and immunities of all Americans who need and want health care from the chiropractic profession, those licensed properly in their States.

Congress should do no less than to guarantee to all patients of doctors of chiropractic the equal protection of the Social Security Act, and I think that means the equal protection of the laws. The best in-

terests of the Government and of the people will be served thereby.

Mr. Chairman, I wish to thank you and the members of your committee for being patient to hear us. We make no brief for any particular kind of health profession, but we believe that the American people should have the right to choose and as they indicated a while ago a larger percent of these doctors practice in rural areas and country areas where no medical doctor will have the time to devote to taking care of these people.

I believe that no harm can come if this privilege is granted. Considerable good can come, and therefore, I urge Congress to seriously consider it, and I believe the cost of care per patient, per doctor, might be even less than the cost today with doctors who are so terribly busy, who are licensed to practice medicine.

We need all these healing arts professions in this country today. Thank you for your consideration.

Mr. BURKE. I want to thank both of you gentlemen for your fine statements here, and, there being no questions, this concludes our hearing for the day, and the committee adjourns now and will meet at 10 a.m. tomorrow morning.

The committee stands adjourned.

(Whereupon, at 3:55 p.m., the committee adjourned, to reconvene at 10 a.m., Tuesday, November 4, 1969.)

SOCIAL SECURITY AND WELFARE PROPOSALS

TUESDAY, NOVEMBER 4, 1969

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The committee met at 10 a.m., pursuant to notice, in the committee room, Longworth House Office Building, Hon. Wilbur D. Mills (chairman of the committee) presiding.

The CHAIRMAN. The committee will please be in order.

Our first witness this morning is our colleague from Missouri, Hon. Durward G. Hall.

Dr. Hall, will you please come to the table?

STATEMENT OF HON. DURWARD G. HALL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

Dr. HALL. Good morning, Mr. Chairman.

The CHAIRMAN. We are glad to have you with us. You are recognized.

Dr. HALL. Thank you very much, Mr. Chairman, and members of the committee. I am delighted to be back.

I don't want to be a perennial every time you have under consideration such important things as the purchasing power and the stability of our social security retirement system, but I think we all realize that it has and is being sorely tested by inflation, by actual and pending threats of raids on its trust fund (from both the disability and medicare programs), some of which were erroneously costed to the Congress by eager salesmen and perhaps bogged-down computers and intermediaries or the administration of the program.

For all of these reasons, I am glad to be back. I have kept in close touch with the problems. Your committee has heard, I understand, that part A of medicare needs a 50-percent increase in funding—and part B needs about \$1.25 increase from both the aged and the Federal Treasury.

My interest in preserving the integrity of the retirement “foundation stone” our social security program, and to assure solid actuarial arrangements for future health programs is literally what compelled me to seek an opportunity to appear as a witness before this committee.

I would hope, as Congress struggles with medicaid for our poor and needy, that a realistic test of need be our goal, in deference to our overburdened wage earner-taxpayer, who expects Congress not to tax them to support others, who are capable of providing health care for themselves.

And in this respect, I might digress to say that my theme remains the same.

But, on the other hand, like all of you, Mr. Chairman, I have been reading about the recent Governors Conferences and their demands for larger Federal participation in medicaid. Additionally, my attention has been attracted to the Reuther, the Rockefeller, and, of course, the American Medical Association proposals.

The Reuther proposal, in my considered opinion and after study, to place the entire population under medicare, is by far the worst of all possible solutions. Blanketing all under one Federal program as it does, when the large majority of our population are well able to, and desire to purchase their own health care programs, to me, is unthinkable, in these times of inflation, tax needs and revision, and dollar declines.

We are today, providing Federal dollars to support more than 50 percent of the cost of medicaid, currently covering 10.2 million individuals. We spend about 4.5 billion Federal and State dollars (2.6 billion Federal), or approximately \$400 per individual per annum.

The Rockefeller plan would have the Federal Government assume the total cost of medicaid, then make it compulsory for the rest of the population to cover themselves with private insurance plans—employers, if any, paying half the cost. Yesterday, I am advised, the American Medical Association suggested both a Federal assumption of medicaid and a tax-credit plan giving incentive credits to persons who purchase their own insurance, with the size of the credit being related to the extent of their income.

In light of this background of possible solutions, and based on my own background, Mr. Chairman, and members of the committee, including my experience in practice of running group associations and running my evaluation as I have been in Congress, I would propose a new two-part program: Not within the social security system but doing away with medicaid and creating a whole new category.

One program that I feel Congress will accept at this time would be directed at the medicaid type recipient. And another, that you might wish to consider more thoroughly at a later date (should Congress decide to institute some type of universal coverage), would, of course, be dependent upon your good judgment.

PART I—MEDICAID

Currently, there are 10.2 million individuals covered by medicaid, all of whom sorely need medical care protection. The young in the ADC program generally don't have high medical expenses. However, the aged are spending about 40 percent of medicare's total dollars and about 30 percent of the total is going into nursing home expense. Yet the average cost per person served is, as I said earlier, around \$400 annually.

This fiscal year, the Federal Government will have need to spend \$2.6 billion and next year the cost would rise to \$3 billion, but the States can't go on meeting their share. In fact, as you well know, about 12 to 16 States haven't even started. I do not propose that the Federal Government take over the whole financial load, but rather we offer each State this proposition: The Federal Government will supply the cost of a health insurance certificate to every eligible and needy recipient. Said certificate will entitle them to a health plan of certain specified basic health protection (defined by Congress) and which

would be purchased from existing private carriers, including the "Blues" and would amount to perhaps 85 percent of the average \$400 annual health care expense, provided, however, that the State will assume the balance of health expenses for each individual who exhausts his basic benefits. In other words, Mr. Chairman, and members of the committee, colleagues, States would assume this rare but financially devastating catastrophic expense.

The merits of this suggestion, as I analyze it, to mention just a few, are:

1. The States will be required to spend less than they are currently spending and could plan, budget, and appropriate for it.

2. The Federal Government will expend approximately a billion dollars more annually—it is 3.6 this year under this plan instead of 2.6—but the Federal Government's share would not be subjected to unexpected escalation, and could be budgeted with fair certainty.

3. When the States are called upon to spend their catastrophic dollars, they will be acting in their traditional and historic role in assuming such long term care, as mental illness and tuberculosis, and presumptive illnesses.

Now, the question arises, who would be entitled to a free health insurance voucher or certificate purchased through existing carriers? This is a critical decision that could be decided, as a suggestion on my part, on the same basis as that used in the Hill-Burton program, where the Federal share is determined by the per capita wealth of a State as compared to the national per capita wealth. Perhaps the average eligibility figure will be in the neighborhood of, say, \$3,000 to \$3,200, where New York, with the high cost of living pegged at \$4,500 to \$4,800 for a family of four could set it at that, and in the case of some of the poorer States where the living is cheaper, the figure could be as low as \$2,600.

So much for the replacement of medicaid, and let's go for a minute to the second part of my proposal.

II. THOSE WHO CAN AFFORD TO PURCHASE THEIR OWN HEALTH PLAN

For those Americans with income above the eligibility line set in part I of my suggestion, and in any universal health plan designed by Congress for the more affluent, I would oppose any Federal subsidy—with one single exception: Protection against economic catastrophic type of injury and illness. I want to repeat that again—for those Americans with income above the eligibility line set in part I—I would oppose any Federal subsidy—with the lone exception being protection against catastrophic-type illness. This is the only area where the Federal Government, in my opinion, should properly involve itself with those who are able to care for their own needs. And it should be noted that catastrophic coverage will need careful definition by the Congress.

Let me give you an example, not by disease category, but by expenditure. Whenever an individual or a family is forced by health reasons to exhaust their life savings, or to mortgage their home, or perhaps have exceeded 30 percent of the past year's income—maybe 20 percent would be better, in your wisdom—then help is needed, in my opinion, even if it has to be from their Government.

Thus Congress might attempt to establish a pool from funds supplied for this specific purpose by the financially able public itself. It could be drawn upon after an individual or family expended a percentage exceeded 20 percent of the level of his last year's adjusted benefits of their health insurance coverage, as I say, when such percentage exceeded 20 percent of the level of his last year's adjusted income, or in your wisdom you may wish to make it the level of his income the month or two just prior to the catastrophic illness but figured on an annual basis.

Gentlemen, I know that the statement I have just read might well come as a shock to those who have in the past thought of me as a foe to any Federal participation in health care. Of course that is not the case, as my support of the "Eldercare" proposal in the 89th Congress will attest.

My suggestions to you have come after seeking information, trying to perceive the problem, long dedicated thought, and, I hope, considered opinion and judgment, based on my professional background, as well as my realization and recognition of changing times, customs, and acceptances in our union of the States.

I have considered some type of catastrophic health coverage for a long time, because I have lived with catastrophe, Mr. Chairman. Yet I have in my own mind hesitated to involve the Federal Government further in the field of individual responsibility than absolutely necessary. However, it is obvious that the time is upon us when changes in the Nation's health programs are on the horizon, if, in fact, not already here. It is, therefore, my intention to try and make the best deal possible, not only for the Government but for the States, the family and the individual.

Mr. Chairman, I think it goes without saying that I am speaking of quality health care for all of our people, not just those in absolute need. I, for one, would like to assure you that members of the medical profession, as a whole, not as represented by organizations necessarily, are also individually concerned about providing continued good quality health care to all Americans.

If I may interpolate, I believe I have heard more doctors express concern not over income, not over socialization of their profession, not over Government intervention, not over any of the other past year bugaboos that we have, but whether under the circumstances in which they find themselves they can continue to render the quality care that their conscience dictates to all of these people or not than any other one concern.

I believe that there is a need for this kind of legislation. I think the time has come for its enactment.

Mr. Chairman, this completes my statement. I am available.

The CHAIRMAN. We thank you very much for coming to the committee and sharing your thinking with us. Your suggestions are very interesting to me.

Any questions?

Mr. BYRNES. Mr. Chairman?

The CHAIRMAN. Mr. Byrnes.

Mr. BYRNES. I would like to compliment the gentleman on a very splendid statement and one that I am sure is very valuable to the committee.

The CHAIRMAN. Mr. Betts?

Mr. BETTS. Doctor, I have received a letter from a doctor this morning objecting to all the programs that have been presented thus far. I am going to send him yours, and I will let you know what he thinks of it. It will be a good test of what one doctor thinks of another doctor's program.

I do want to join with my colleagues. I think your statement gives us a lot to think about and I know it represents a lot of thought and work.

Along the way did you happen to discuss it with any State health officials to see what their reaction would be to responsibility for meeting the catastrophic illnesses?

Dr. HALL. I have not. This is my own distillation of thought and experience. I can elaborate on it a little bit for your benefit and I want to emphasize what I believe I did say in the statement, Mr. Chairman.

Catastrophe is really rare in the confines that we have set up here. It is true that a physician walking down the wards of a hospital is used to catastrophe. It is further true that the stories that you read about represent catastrophe, but in the milieu, in the percentage of involvement in good medical care and restoration and rehabilitation, the long-term catastrophic case that affects to this degree that I have set out as a feeler here families and their incomes is relatively rare and the happiest thing about it is it is inexpensive to insure against.

I am simply trying to say that I think we could strike a blow for freedom and for helping our people if we are going to involve Federal dollars in this area easier than we can in any other area to take the devastating case that ruins the pocketbook and requires people to mortgage the home in the relatively rare instances where insurance should be a big factor, and possibly with coinsurance. That would be up to the wisdom of this committee. To answer your question. The Governors should be pleased since my plan would save them money. About 20 percent less than they are now spending.

Mr. BETTS. Thank you.

Mr. SCHNEEBELI. Mr. Chairman?

The CHAIRMAN. Yes, Mr. Schneebeli.

Mr. SCHNEEBELI. Dr. Hall, I see that you deviate considerably from your colleagues in AMA in this group above the eligibility line. I think in their discussion yesterday the AMA said there were approximately 30 percent of the people below the eligibility line, and then 50 percent between the \$300 and \$1,300 tax bill base. You would rule out any Federal type of help in this latter area except for catastrophic type cases, would you not? This would be the big bulk of the AMA program cost. As you know, they said that their cost would start at \$12 billion a year minimum and, of course, then we take off from there. I would assume, since you rule out everything except the bottom 30 percent, that the cost of your recommendations would be considerably less. I see that you say it is \$3.6 billion.

Dr. HALL. \$3.6 and it might go up to \$4.46 in the next fiscal year, which, of course, you are concerned with.

I think your question proves the answer to Congressman Betts that I have not coordinated this with any other outside organization. This is my own distilled thinking. I want to say that my figures come not from any outside source but from the HEW actuaries themselves. I

have accepted those, although we collectively have found in the past that sometimes they do vary in estimates, but these figures that I am using here are based on HEW.

Now, in further answer to your question, which I think is a very delving and perceptive question, I am not familiar with the AMA testimony, except that I was briefed on it yesterday afternoon, but I think you will recognize immediately—indeed, I think you have recognized—that they are talking about the across the board total gamut of medicare.

Mr. SCHNEEBEL. Medicaid.

Dr. HALL. Well, medicaid, title 19, as we think of it specifically.

Mr. SCHNEEBEL. Yes.

Dr. HALL. I have visualized this in three different compartments, if I can compartmentalize my own mind, one, the replacement of medicaid by those really needy, truly destitute as determined by the States, the so-called welfare people, we would give them the certificate of casualty health insurance.

Then, second, we would at this time, I am ready to recommend, also ask that a way be devised to insure all people against catastrophe.

Now, this leaves, in effect, medicare or title 18, parts A and B, and that would continue and the Congress, and this committee in particular, can develop its own devices in the future or maybe if you have additional hearings next year I will then be ready to come back and tell you what I think might be a solution for the group in between which I think the other testimony included, and this accounts for the difference in values assigned.

Mr. SCHNEEBEL. Well, the American Medical Association, I think, surprised most of us committee members by the comprehensive coverage and cost of all of it and I think that your approach is a lot more reasonable, at least at the outset, where you limit the general coverage to the people below the eligibility line.

Dr. HALL. And who are in need.

Mr. SCHNEEBEL. That is right. And in your concern for the catastrophic type of cost, you sort of parallel the thinking of your former colleague from Missouri who was on this committee and kept talking about it all the time, Congressman Tom Curtis. He was particularly a proponent of the coverage in this area and this is the area that concerned him greatly, and I see that you must have been talking with him for you people in Missouri have the same type of thinking.

Dr. HALL. We have the same type of thinking, I hope. I wish I was as erudite as he was, and we miss him, but be that as it may, I honestly believe, I will say to my colleague from Pennsylvania, that my feeling about catastrophic injury comes from experience. You know, I did a tremendous amount of cancer surgery. I was in a group that did a lot of reconstructive surgery. In the old days, gentlemen, I wasn't above, when we would come up against one of these cases and it came time to turn in the bill, just say, "No charge." Now, those things have changed. We are recognizing a sign of the times here and changing times and someone else has assumed that burden, at least 80 percent of that burden, let's say, or 85 percent of it. Be that as it may, these are the killer cases, but fortunately they are rare, relative to all other cases, all other health care benefits extended, and fortunately they are easily insured against at a minimum of expense, and if we are going

to continue to, as we must, even under our revised tax program, to skim off federally the cream on the top of the crock then I think with these changing times this is an area where we can make a very popular, a very great, to those who are socially conscious for need of care, contribution and certainly it would help our hospitals. It would help our institutions that provide this reconstruction and rehabilitation.

Mr. SCHNEEBELI. Speaking further about this catastrophic type of illness, is it difficult to know when a case goes from the ordinary type of illness to catastrophic? Isn't there a gray area here where it is difficult to determine just what constitutes this type of illness?

It seems to me qualified somewhat as to the cost of the illness and what we are talking about is more catastrophic cost, is it not, rather than catastrophic type of illness?

Dr. HALL. That is correct.

Mr. SCHNEEBELI. Would this have to be in the area of a certain amount of money? Beyond that, we get the catastrophic cost, and is it based more on a cost than the medical type of analysis or definition?

Dr. HALL. I think the gentleman has hit it exactly. It is the two penultimate paragraphs on page 3 of my testimony. I tried to set this out. I want to leave it to the committee's wisdom to define that.

It must be defined very carefully. I think you can relate it to annual or monthly income or percentages thereof. I quite agree with you it isn't just the question of type of disease.

Mr. SCHNEEBELI. Yes.

Dr. HALL. There is a gray area, but with our utilization committees that we have established in existing law, I think it would be very little of a problem to decide when a continuing case in hospital or in nursing home is reaching catastrophic proportions with relation to that family's recorded history.

Mr. SCHNEEBELI. I agree it is a good type of cost-related disability and that this type should be recognized, maybe we will have to look to you for a definition.

Dr. HALL. I am always available to help this committee, as you know.

The CHAIRMAN. Any further questions?

Mr. Ullman?

Mr. ULLMAN. I just want to say to our colleague from Missouri, who is a very eminent physician, one with extensive experience, that we appreciate his coming before the committee and as usual giving us constructive suggestions rather than just criticism. This is the kind of testimony we like to hear and I particularly appreciate having you before the committee.

Dr. HALL. I certainly thank the gentleman.

The CHAIRMAN. Any further questions?

If not, again we thank you, Dr. Hall, for coming to the committee.

Dr. HALL. Thank you.

The CHAIRMAN. We have with us today Hon. Harrison A. Williams, Jr., the distinguished Senator from the State of New Jersey. You may come forward and present your statement to the committee, sir.

Senator WILLIAMS. Thank you, Mr. Chairman.

STATEMENT OF HON. HARRISON A. WILLIAMS, JR., A U.S. SENATOR
FROM THE STATE OF NEW JERSEY

Senator WILLIAMS. The comprehensive hearings on social security legislation, which the House Ways and Means Committee is now holding, represent a timely opportunity for a thorough review of the present and potential roles of our social security system in assuring economic security to the Nation's older population.

I think you know that the Senate Special Committee on Aging has been concentrating its attention on this subject during the past year.

In a report to the committee entitled, "Economics of Aging: Toward a Full Share in Abundance," a distinguished task force concluded that the social security system "has failed to keep up with the rising income needs of the aged." The task force also said:

"The existing social insurance system is a fast and effective way to deliver an income assurance that carries commitments for the future as well as for the current generation of aged."

My preface to the task force report issued on March 24, 1969, pointed out:

"The economic problems of old age are not only unsolved for today's elderly, but they will not be solved for the elderly of the future—unless the nation takes positive, comprehensive actions going far beyond those of recent years."

The hearings which we have held on the Economics of Aging have added to my conviction that the retirement income problems of today and tomorrow will not be solved by adding a few dollars every 2 years to social security benefits. It is clear that more fundamental changes in the social security system are needed to serve as the foundation for economic security now and in the future.

I urge therefore that the House Ways and Means Committee initiate the study of these more fundamental changes.

The revised social security bill that Congressman Gilbert has introduced on October 21 provides an excellent focal point for this study. There are other essentials to broad reform of the social security system—consistent with the objectives of Congressman Gilbert's bill—that I urge be considered simultaneously. These essentials are included in five bills to amend the Social Security Act that I introduced on May 27, 1969. At that time I said:

"What I look for in the next few months is the evolution of an omnibus bill which will serve as a worthy vehicle for Congressional debate at the earliest possible date.

"Today I am not introducing that omnibus bill. But I am introducing several proposals which I regard as essentials without which the final bill would be incomplete."

The relationship of my earlier bills to the bill Congressman Gilbert has introduced follows:

S. 2270 A bill to amend Title II of the Social Security Act to permit the payment of benefits to a married couple on their combined earnings record where that method of computation produced a higher combined benefit.

S. 2270 would eliminate a social security inequity against married couples where the wives work. The Gilbert bill does not deal with this problem and hence the proposal of S. 2270 is also needed as part of comprehensive reform.

S. 2271 A bill to provide for the conduct of certain studies by the Secretary of Health, Education, and Welfare with respect to the insurance program established by Title II of the Social Security Act.

S. 2271 proposes three studies. The first of these is an analysis of various approaches to automatically adjusting benefits, including a cost-of-living adjustment. The bill Congressman Gilbert has introduced provides that benefit amounts would be automatically adjusted annually for each 1 per cent or more of increase in the cost-of-living. There is still need for the broad study proposed by S. 2271 which would encompass methods of adjusting benefits to productivity and rising standards of living and would also assess the appropriateness of the use of a cost-of-living index based on the needs and spending habits of the total population.

The second study proposed by S. 2271 related to general revenue financing. The fact that the Gilbert bill provides for general revenue financing gives assurance that careful attention will be given to this subject.

The third study proposed by S. 2271 concerns the trend toward retirement before age 65 and the effects of that trend upon individual social security beneficiaries. The Gilbert bill would lessen the actuarial reduction imposed on persons claiming benefits before age 65 but it does not eliminate the need for a broad study of the trend toward early retirement.

S. 2272 A bill to amend title II of the Social Security Act to increase the amount of the insurance benefits payable to widows and widowers.

S. 2272 would no longer be needed because the bill introduced by Congressman Gilbert raises the proportion from 82½ per cent to 100 per cent of the worker's benefit where the survivor's benefit begins at age 65.

S. 2273 A bill to amend Title II of the Social Security Act to increase the amount of earnings permitted each year without deductions from benefits thereunder.

S. 2273 would no longer be needed. The Gilbert bill proposes the same liberalization of the "retirement test" and in addition provides for automatic adjustment of the annual exempt amount of earnings under the retirement test.

Since introduction of S. 2273 I have become even more aware of the impact of the present retirement test on the participation of older workers in gainful employment. I hope the House Ways and Means Committee will address itself to two questions:

(1) If benefits are raised as contemplated by the Gilbert bill, would pressures for the elimination of the retirement test be reduced? and
(2) What additional costs would be involved in eliminating the retirement tests proposed by the Gilbert bill and proposed by President Nixon?

S. 2274 A bill to amend title II of the Social Security Act so as to provide that remarriage shall not disqualify an individual from receiving widow's or widower's benefits thereunder.

S. 2274 would still be needed to deal fully with the problems of reduction or elimination of social security benefits on remarriage.

The CHAIRMAN. Are there any questions? If not, thank you so much for giving of your time to come here today.

Senator WILLIAMS. Thank you, sir, and the other members of the committee.

(The following excerpt was received by the committee:)

EXCERPT FROM DEVELOPMENTS IN AGING, 1968, ANNUAL REPORT OF THE SENATE
SPECIAL COMMITTEE ON AGING

CHAPTER XII—THE GROWING NEED FOR TRAINED PERSONNEL IN AGING AND RELATED FIELDS

As the number of older Americans increases, so does the demand for specialized services and trained administrators for many kinds of facilities, including housing, intended to serve the elderly. Aging has thus produced many growth industries, but government and private resources have not yet been

successful in providing the specialists needed now and even more so in the future.

Fortunately, the most comprehensive evaluations made yet about the size and nature of the problem were produced in 1968. In addition, significant steps have been taken to provide innovative training, and educators and others have participated in courses meant to help them develop training programs in aging at universities and other educational institutions.

I. The 1968 surveys of the problem

Congressional concern¹ about training needs resulted in a request that the Administration on Aging undertake a study and evaluation of the immediate and foreseeable need for trained personnel to carry out programs related to the objectives of the Older Americans Act. In 1968, the following major findings were reported:

OVERALL NEEDS: Under an AoA contract, the Surveys and Research Corporation issued a report² which made the following major points:

Most if not all service programs are faced with critical shortages of trained personnel. The outlook is for little improvement in this regard unless drastic changes are made in the scope and character of the training effort.

At least a third of a million professional and technical workers are employed in programs serving older people exclusively or primarily. In all likelihood, fewer than 10 to 20 percent of these have had formal preparation for work with older people. A projection of future demand, if necessarily a gross one, would place requirements for trained workers in 1980 at a level 2 and 3 times above that of 1968.

Home medical care programs and the provision of social services to older people through social agencies appear destined for major expansion. As these programs grow in number and size, they will make demands for personnel. The need for social workers, social work aides, and community aides trained to serve older people in public-welfare agencies, long-term care facilities, information-referral services, retirement-housing projects, and in other facilities, largely unfulfilled, runs into many thousands.

One of the most serious deficiencies turned up by the present study is the paucity of basic information on the demand for and supply of personnel in the field. The first recommendation in the report is addressed to this subject, in recognition of the fact that such information is fundamental to efforts to recruit personnel and to provide training opportunities.

PROBLEMS IN HOUSING: Another AoA contract went to the National Association of Housing and Redevelopment Officials. As a result of NAHRO's survey, the following statements were provided in the final report:

Management personnel in governmentally assisted housing projects designed for occupancy by the elderly currently number about 4,900. Few have had specialized preparation for working with older people. Estimated requirements for such personnel in 1970 range from 8,000 to 13,000. Corresponding figures for 1980 are from 32,000 to 43,000.

An even more compelling need for trained personnel exists in the field of nursing and personal care homes if these facilities are to provide adequate medical care, restorative services, and stimulating activity programs. Some 24,000 persons are employed in administrative capacities in such homes at the present time, most of whom will require special training if they are to meet licensing requirements now being developed in response to the Social Security Act Amendments of 1967. A special analysis made for the present report points to the strong likelihood of a doubling and a tripling in the number of beds in use by 1980, with a need for corresponding increases in the number of trained personnel.³

RECREATION PERSONNEL: A third contract—granted to the National Recreation and Park Association—was used for a study of personnel needs in the field of recreation. The report declared:

¹ See pp. 142-143. "Developments in Aging, 1967", for discussion.

² The Demand for Personnel and Training in the Field of Aging, Oct. 1, 1968. (Later submitted to the Congress by HEW Secretary Cohen.)

³ For additional discussion of the NAHRO study findings, see "Study of Housing Management for Elderly Points up need for More, Better Trained Management Personnel for All Low-Income Housing," an article in the Journal of Housing, No. 10, 1968.

... at present there is a full-time equivalent of approximately 15,000 recreation personnel working with older adults. Projected needs are for 23,000—31,000 such workers in 1970 and 26,000—76,000 in 1980.

The C & S report, seeing a clear need for widespread training efforts at universities and elsewhere, made 23 recommendations.⁴

Survey data clearly indicates a widespread need for more trained personnel in many fields related to aging. Unless great efforts are made to provide such personnel, Federal funds will not be put to best possible use in programs and for purposes of direct importance to elderly Americans. Early congressional consideration should be given to recommendations made in 1968 and to other proposals that may arise.

II. Training programs now at work

A large number of training programs are described in appendix 1⁵ reports from the Administration on Aging, the Social and Rehabilitation Service, the Public Health Service, the Office of Economic Opportunity, the National Institute of Mental Health, and the U.S. Office of Education. The purpose in most cases is to provide support, as far as is possible at present levels of funding, for training of specialists.

Other possibilities for more widespread dissemination of information about aging are suggested by the use to which Administration on Aging funds have been employed in programs that bring representatives of many disciplines of higher education together for intensive lecture and discussion programs.

In New Jersey, the State division on aging conducted two seminars on gerontology and higher education during 1968. Universities, schools of nursing, and community colleges were represented on each occasion. Conferees met from February 1-4 and February 23-25 for the first seminar and for a similar number of days for the second.⁶

Another AoA grant was used in 1968 to fund seminars in social gerontology for faculty of Michigan educational institutions. The University of Michigan—Wayne State University invited faculty of universities and colleges (including junior and community colleges) to conferences intended to help them develop their own training programs in aging at their educational institutions. The seminar consists of eight weekend sessions (Friday evening, Saturday, and Sunday morning) a month apart.

The CHAIRMAN. Our next witness is the Honorable Carl D. Perkins from the State of Kentucky. Mr. Perkins, please come forward to the witness table, if you will and you may proceed as you wish.

Mr. PERKINS. Thank you, Mr. Chairman.

STATEMENT OF HON. CARL D. PERKINS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KENTUCKY

Mr. PERKINS. Early in the present Congress I introduced two social security bills—one increasing benefits by 20 percent across the board and making both men and women eligible at age 60; another extending medicare to people eligible for disability benefits. In view of the fact that the administration has just now proposed an increase of only 10 percent, along with other changes in the system, and the Committee on Ways and Means is now conducting hearings on that bill, I want to make it plain that I consider such a small increase as 10 percent quite inadequate in times such as these and in view of the present level of benefit payments.

I remind the Congress that the average benefit for a retired worker lacks a few cents of being just \$100 a month, while the average benefit for an aged couple is only \$168 a month. I maintain that the proper increase for social security benefits, in time such as these, should be

⁴ See app. 9, p. 271 for summary.

⁵ Pp. 128-129, 144, 153, 160, 203.

⁶ For additional details, see app. 9, Item 2, p. 271.

at least twice the amount the administration has recommended. Such a change would also increase the minimum benefit from \$55 to \$66 and raise the maximum benefit from an eventual \$218 to \$261.60. The 20-percent increase contained in my bill, H.R. 3287, introduced on January 14 of this year would bring the retired workers' average benefit up to \$120 and the aged couple's benefit up to around \$202 a month or around \$2,400 a year.

According to the Labor Department's Bureau of Standards the amount required for an aged couple to maintain a "moderate" living standard in urban areas of the United States is \$4,112 a year. This budget allowed \$1,113 a year for food, \$1,377 for housing, \$364 for transportation, \$379 for clothing and personal care, \$314 for other family needs and \$246 for gifts and contributions. The budget assumed that "urban areas" included a metropolitan area or smaller city. It also assumed that both the man and his wife were in reasonably good health for their age, able to take care of themselves, and fully covered by medicare. They also had average inventories of clothing, home furnishing and major durable goods, such as a washing machine, a stove, a refrigerator and a vacuum cleaner already on hand. This, as we know, is not always the case.

Perhaps 20 percent is not enough. Perhaps we should think in terms of making it possible, through our social security system, for most people to look forward to solving the poverty problem, as it is related to income, for all of our elderly citizens so that we can all look forward to retiring with the assurance of a "moderate living standard" such as I have just described. A statutory advisory council on social security now meeting is charged with reviewing "the scope of coverage," the "adequacy of benefits" and "all other aspects" of the social security and health insurance programs and is probably considering this matter. It must report its findings and recommendations to the Secretary of Health, Education, and Welfare, for transmittal to the Congress, by January 1, 1971.

Another aspect of the program which I believe should have the particular attention of the Congress is the current and complicated retirement age. My bill, H.R. 3287, would reduce the retirement age to age 60 for both men and women, paying them full benefits if they need them at that age. One of the first bills I introduced into the Congress when I came here some years ago, was a bill to lower the eligibility for retirement age to age 60 for both men and women. At that time it had been obligatory that the age 65 for both men and women was the required age—which was then obsolete, in my opinion, because it was adopted in the original Social Security Act back in 1935. Since that time we have developed an extremely complicated mechanism which pays full widow's benefits at age 62 but actuarially reduced benefits for wives and women workers at age 62, to widows at age 60, and even more steeply reduced benefits to men who chose to retire at age 62.

I emphasize the fact that changing the retirement age does not make it mandatory retirement age. If a man or woman wants to continue working after age 60, that is entirely up to him or her. But I also emphasize the other fact that retirement age is not, for the individual, always a voluntary matter. In some cases it is the decision of his employer or a supplementary pension plan, that he is no longer employable after age 60. In other cases he is "laid off" because of a

slight disability which makes it difficult to keep up the pace of production at which he formerly performed. Instead of being automatic at age 65, "retirement" is in real life and arbitrary, capricious and unpredictable phenomenon. Lowering the retirement age to age 60, I have always believed, is a means of adjusting to this fact of life. For those people who are fortunate enough to continue on the job to age 65—or beyond—our present system works. For those who have the misfortune to be laid off, or to be unable to find a new job before they reach that age, the age 60 retirement age offers an alleviation of what has been called the "valley of despair" between enforced retirement at an earlier age and the attainment of the statutory retirement age. This is particularly true in an economy requiring changing job skills and which is adjusting to automation.

The second major improvement required in our social security system, in my view, is the extension of the medicare provisions, now available only to people aged 65 and over so that people who are receiving benefits because they are severely disabled can qualify.

I lay claim to having been one of the earlier sponsors of providing cash benefits for people retired from the labor market because they have been so severely disabled—a concept finally approved in the 1956 amendments to the Social Security Act and since expanded. The time has now come to go beyond the mere entitlement to cash benefits and to provide the disabled with the medical and hospital care which they quite obviously need. Here again, I will lay claim to being an early advocate. At the time the 1965 amendments which created the medicare program were being considered, I appeared before the Committee on Finance of the Senate to urge such an extension. The report of the advisory council on social security which appeared in 1965, had also advocated such an extension and viewed the disabled as being as much in need of such care as were the aged. In their view "Older people and disabled people have a special need for protection against the cost of hospitalization and related services—they need more care and they have less money to pay for it."

The Congress recognized the problem 2 years later in 1967, but because of uncertain cost factors, at the time, wrote into section 140 of the Social Security Amendments of that year the provision for a special Advisory Council on Health Insurance for the Disabled. It was directed to study the question of extending medicare to the disabled, to determine whether there was an unmet need for health insurance protection for them, and to examine the costs and financial feasibility of such a program.

Their report, which appeared in January of 1969 found that disabled workers who qualify for social security disability benefits use seven times as much hospital care, and three times as much physicians' services as do the aged. They found, as well, that the median income of disabled worker beneficiaries is less than half that of the rest of the population.

In their view "The predominantly high health costs and relatively low incomes of the severely disabled make it unrealistic to expect private voluntary insurance alone to provide the great majority of them with comprehensive protection over the entire period of their disability." The Council concluded that "It is appropriate, feasible, and desirable to use the social insurance approach" used in medicare, to meet this situation. Noting that the level cost of its recommendations

would be 80 percent of payroll, the Council recommended that, of this amount, 40 percent of taxable payroll be charged to employers and employees in equal shares, and the other half from general revenues. Among their findings was the fact that using the Social Security Administration's poverty index, which takes family size, sex, and age of family members into account, half of the disabled worker beneficiaries were "poor or near poor" and one-third were at or below the poverty level. Recognizing the fact that the benefits of medicare would not be appropriate to the needs of the disabled requiring long-term care, which some of the disabled may need, they concluded that it does cover the types of care needed by most of those who are disabled.

My bill, H.R. 2378, introduced on January 7, 1969, would provide such protection not only for disabled workers but for children with benefits based on disability. It is identical with the bills introduced into the Senate by Senators Vance Hartke and Walter Mondale. Altogether some 30 bills representing 57 sponsors using a similar approach have been introduced in this Congress. I am heartened by the fact that you have expressed your concern and interest in such legislation. We have now abundant evidence of the need for it and of its feasibility. I regret that it was not included in the recommendations made by the Nixon administration, but I look forward to its early enactment because of its widespread support.

I approve of one feature of the administration bill regarding the increase in widow's benefits. As you know, under present law, a widow who begins receiving benefits at age 65 is entitled to just 82.5 percent of the amount her deceased husband would receive if he were alive. Under the administration proposal, such a widow would be entitled to 100 percent of this benefit, if she is 65 or over, but the widow going on the rolls at age 62 would have her benefit actuarially reduced above the present 82.5 percent level. I am impressed with the fact that some 2.7 million people would have their benefits increased by this provision. Additional benefit payments under the administration bill in the first 12 months are estimated at \$580 million. But in line with my thinking about the proper retirement age, I would have to oppose the actuarial reduction for widows below age 65 contained in this bill.

We have a social security system as an accepted institution—one that does a substantial share of what needs to be done but which needs to do more. Under it eligibility for benefits and the amount of cash benefits are based on past earnings and so are paid as a matter of right. It is a universal system which provides basic protection to the entire population following the worker wherever he moves and at the same time it has the flexibility which enables it to adjust to changing economic conditions. We do not always realize, I think, that one out of every eight persons in the country now receives a social security cash benefit every month, including those payments made to wives, surviving widows, and surviving children. Over 90 percent of all people now reaching age 65 are eligible for social security benefits.

The present Commissioner of Social Security, Robert M. Ball said, in January of this year:

Perhaps the most basic question . . . [is] related to the general level of benefits. Social security benefits are the most important source of continuing income for persons who have retired. Successive studies have shown that the majority of beneficiaries have negligible amounts of other income or assets that could readily and prudently be converted to cash. This situation is not likely to change very significantly in the future.

What is a reasonable level will, I am sure, be subject to continuing debate, as it should be. At present, of nearly 25 million social security beneficiaries, about 10 million are able to live above the poverty level because of their social security benefits. [But] only about 5 percent of the aged could live at a "moderate" standard as defined by the Department of Labor without their social security benefits.

We are all aware that the recent sharp increases in the cost of living, which are hard on all of us, are hardest of all on retired people living on fixed incomes. The Congress is concerned with the fact that the consumer price index climbed 4.5 percent in the first 9 months of this year, compared with a 3.4 percent increase for the same period in the 1968 period. It rose to a 6 percent annual rate in September 1969 after climbing to a 4.8 percent rate a month earlier. The gain last month brought the cost-of-living index to a record 129.3 percent of the 1957-59 average. There seems to be agreement on nearly all hands that some upward adjustment of social security benefits must be made as a result.

I am concerned that we go beyond considering increases in the amount of these benefits solely on a cost-of-living basis. Such an increase in the 1967 amendments has proved to be insufficient for today's prices, and so we must make another adjustment, so the reasoning goes. I am concerned with going beyond that reasoning with an increase of at least 20 percent at this time so that the level of benefits—and I have shown how pitifully inadequate they now are—will be brought up to date. As I have said, I am also concerned with further modernizing our social security plan by reducing the retirement age to 60 for everyone, and with extending our medicare benefits to the severely disabled. It is time, I believe, to forego the stop-gap approach to changing the social security law and think in terms of a program that looks to the future and to future needs in a realistic way. It is toward this end that I am proposing the changes I espouse here today.

The CHAIRMAN. Thank you for your statement, sir.

Are there any questions? There are none.

Mr. PERKINS. Thank you.

The CHAIRMAN. Our next witness is our colleague from the State of Texas, the Honorable Kika de la Garza. We appreciate your taking the time to come to the committee. You may identify yourself for the record and proceed, sir.

STATEMENT OF HON. KIKA DE LA GARZA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. DE LA GARZA. Mr. Chairman, I appreciate the opportunity of appearing before your committee on behalf of three bills I have introduced in the House in the present session.

The first, H.R. 179, would correct an inequity in the present law under which children adopted by persons who are disabled or become disabled are entitled to benefits only if the adoption took place under the supervision of a public or private child-placement agency.

It seems to me self-evident that if a child is legally adopted through action of a court of competent jurisdiction it should have equal protection under the law and equal rights with any other adopted children. Furthermore, I have been informed by the Department of Public Welfare in my State that there are simply not enough qualified child-placement agencies in Texas to act in every adoption before

court action takes place. No doubt the same situation exists in many other States. The court action makes the adoption legal, and the adopted child has a right to support as well as love and affection from its adoptive parent from the date of adoption.

My second bill, H.R. 774, would amend the Social Security Act to require States to disregard proceeds of insurance in determining eligibility for public assistance when the insured dies in the active military or naval service.

This change in the law is needed to remove an unfair penalty imposed upon families of the men upon whom our Nation depends to protect the national security. It is no secret that many of these men come from disadvantaged families who are dependent upon assistance from public welfare funds. Their loss of eligibility for such assistance if they become beneficiaries of GI insurance policies has in many cases caused suffering and hardship.

My third bill, H.R. 14164, would amend the Social Security Act so as to remove the limitation upon the amount of outside income which an individual may earn while receiving benefits under the law. Almost one and three-fourths million people lost some or all of their social security benefits last year because they had income from work. People need to be encouraged to work—not discouraged from working. Removal of the archaic provision that limits earnings would place an estimated \$2½ billion a year in the hands of our aged population.

Mr. Chairman, I urge favorable consideration by your committee of these measures. Thank you.

The CHAIRMAN. Are there any questions? Mr. de la Garza, we thank you for being with us today.

The next witness today is Congressman John J. Duncan from the State of Tennessee. Would you please identify yourself for the record and you may proceed as you wish, sir.

STATEMENT OF HON. JOHN J. DUNCAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Mr. DUNCAN. Mr. Chairman, I would like to encourage you and other members of your distinguished committee to give favorable consideration to the proposals before you that would increase benefits to social security recipients.

My files are replete with hopeful inquiries from constituents who wonder how long they will be able to survive on the small checks they receive each month. As you know, labor keeps demanding higher and higher wages and many professional salaries are going up. The cost of living continues to rise, but the folks at home who have to depend on their social security benefits have to pinch pennies more and more.

Among the bills now pending action are some I have introduced to strengthen our social security program and to offer increased benefits to widows of insured individuals.

Raises have been few during the past 9 years. The Kennedy administration entered office in January, 1961, and was followed by the Johnson administration. It was, however, not until July 30, 1965, over 4 years later, that the Democratic administration granted an increase, and this was for 7 percent. The last increase was for 13 percent and was approved by the 90th Congress on January 2, 1968.

On August 1 of this year I submitted a petition to you bearing the names of 74 members of the House of Representatives who urged immediate hearings on increases. Since that time many more have voiced the need for legislating increases, and the mail I receive concerning this matter has increased considerably in recent weeks.

As you know, it has been 2 months since President Nixon asked Congress for a 10-percent across-the-board increase in social security benefits to make up increases in the cost of living. He suggested that these benefits become effective in April of 1970, and that future benefits be adjusted automatically to take care of increases in the cost of living.

I am hopeful that we can pass social security legislation this session. I favor a 15-percent increase, but would settle for a 10-percent increase rather than see these citizens suffer further.

The CHAIRMAN. Thank you for coming to the committee today. Are there any questions? Again, we appreciate your statement.

Mr. DUNCAN. Thank you.

The CHAIRMAN. Our next witness is the Honorable Shirley Chisholm from the State of New York.

STATEMENT OF HON. SHIRLEY CHISHOLM, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mrs. CHISHOLM. There has already been a great deal of criticism of the President's proposed welfare and social security reforms. Much, if not most of the criticism, has been constructive in nature. I too, desire to add my voice to the chorus of critics.

The most obvious fault one finds immediately in the reform proposals is their patent inadequacies. Indeed, Mr. Finch, in his statement of explanation of the bill said :

For those who cannot work, there is a more adequate level of Federal support. Mr. Finch through his use of the words "more adequate" seems to concede that the proposals are indeed inadequate.

The President in his August 8 address to the Nation accurately voted "that it (the present welfare system) is failing to meet the elementary human, social, and financial needs of the poor." It is my contention that the proposed new reforms will continue, not ameliorate, our present problems. The true issue is whether or not we should provide an adequate income for both the working and the nonworking poor. We have only rarely hesitated to provide adequate subsidies for both domestic and foreign private business enterprise in order to insure economic health. Is it not reasonable therefore to provide adequate support for those private individuals, who for various reasons are unable to work?

It sounds as if the administration is preparing to allow the newly proposed welfare reforms to die in the same way that it allowed black capitalism to die.

If they were allowed to die it would not be a great disaster—except for the Southern and rural States that stand to benefit most by the proposal.

Let me try briefly to explain some of my oppositions to the proposed reforms.

Firstly, as most of us already know, \$1,600 is a patently inadequate amount. Forty-three States already pay more than that; recipients in only eight or 10 States, mostly Southern, would experience an increase in benefits.

Secondly, the compulsory work aspect smacks a bit of involuntary servitude; even more it would seem to be founded on nothing more than the assumption that welfare recipients do not want to work. That simply is not true.

In 1967, the research department of the City University of New York released a report entitled "Families on Welfare in New York City," authored by Lawrence Podell. The major findings of the report were that seven out of 10 welfare mothers indicated that given suitable employment or training, they would work; further two out of three indicated that they had definite plans to work in the future.

But there is more wrong with the work requisite factor in the proposal than the false assumption that it is based upon.

The Nixon proposal would provide some \$828 per child per year for day-care facilities. That is \$172 less than the minimum estimate of \$1,000 per child advanced by some authorities. My own experience as a day-school administrator leads me to believe that even the \$1,000 figure would not be sufficient to provide more than barely adequate care and facilities.

That, of course, means that the difference will have to be provided by the low-income family or recipient, as the case may be. The Nixon proposal does not seem to have considered that point and the possible eroding effect it would have on the families' income.

Also there is no doubt that the 150,000 new jobs that Mr. Nixon proposes is woefully inadequate. The recent rise in unemployment has removed at least that many old jobs from the economy already. And before the spring of 1970 it is estimated that the administration's tactics against inflation will produce some 1 million more newly unemployed. The official figure for nonwhites is expected to rise to about 8.5 percent while the figure for whites is expected to hold at a steady 4 percent.

Then consider the fact that New York State alone could use over 300,000 jobs for present welfare recipients and one begins to have some idea of the extent to which the administration's proposal misses the mark.

There is also the unanswered question of the food stamp program that must be considered when evaluating the proposed reforms. Early this year, the administration proposed to extend the program; then the President's initial welfare reforms proposed to do away with it entirely; now administration officials are again proposing that it be retained.

They are now saying that a recipient family of four should be allowed \$480 with which to purchase stamps which could be redeemed for \$1,200 in food. That figure, \$1,200, is presumably arrived at because USDA figures indicate that as a minimum for an adequate diet. The proposal does not seem to take into account at least two factors: (1) food money is the only flexible item in the recipients' budget; (2) food as a budget item assessed by the Government figures would be 30 percent of the \$1,600 minimum. (On this point Senator McGovern has pointed out that the average family of four spends only

17 percent.) As a result, we would be asking the recipient to spend 13 percent or almost half again as much as a nonrecipient. In short, it becomes in reality a way to further penalize the poor for being poor.

The final question one must raise in considering the scope and the impact of the proposed welfare reforms is the question of adequate income.

The U.S. Department of Labor considers a yearly income of \$6,207 as necessary to maintain a low but acceptable standard of living for a family of four in an urban area.

In New York City the figure is held to be \$6,201, slightly lower. The typical recipient family of four receives only \$3,756 with sanctions against their attempting to maintain that necessary flooring while striving to raise to the "acceptable" lower standard based on \$6,000. The Nixon proposal clearly does not begin to resolve this situation.

What it does instead is attempt to force the poor into accepting low-paying, dead end jobs and as a consequence encourages industry to provide them.

Almost everyone, from Dr. George Wiley, of the National Welfare Rights Organization, to George Meany, of the AFL-CIO, has criticized the proposals but, by and large, the criticism has been constructive in nature. The proposed reforms do represent a step in the right direction. But they just don't go far enough.

Similarly, neither do the manpower proposals. First of all, our minimum wage of \$2 per hour produces only \$4,160 per year; only some \$404 per year above the welfare average in New York of \$3,756 per year. From that perspective, it becomes inadequate as incentive.

Viewed from the perspective that it takes (according to the USDL figures already mentioned) \$6,207 to maintain a decent standard of living in an urban area it must cause one to wonder whether or not we intentionally maintain a class of people we euphemistically tend to call "the working poor."

The basic strategy of the Nixon administration's manpower policy has been keyed to the State operation of most aspects of the manpower programs.

I am and have been against this strategy on the basis that the State programs have been traditionally more bureaucratized and intransigent to change. It has also been pointed out, and with some just cause, that they have traditionally provided a source of cheaper labor for business and industry. And finally, there is their traditional relationship with minority-group unemployed. Therefore, I consider the administration's position as a regressive one.

The CHAIRMAN. Thank you for your statement, Mrs. Chisholm.

Mrs. CHISHOLM. Thank you.

The CHAIRMAN. Our next witness is Mr. Karl T. Schlotterbeck.

Mr. Schlotterbeck, we are glad to have you back with the committee. You have been before us on many occasions in the past, but we would like for you to again identify yourself for this particular record.

STATEMENT OF KARL T. SCHLOTTERBECK, MANAGER, ECONOMIC SECURITY, CHAMBER OF COMMERCE OF THE UNITED STATES

Mr. SCHLOTTERBECK. Thank you, very much, Mr. Chairman.

My name is Karl T. Schlotterbeck. I am manager, economic security, for the Chamber of Commerce of the United States, and I am here speaking today on behalf of the national chamber.

We appreciate this opportunity, Mr. Chairman, and members of the committee, to present the chambers view on H.R. 14173.

The national chamber is the largest association of business and professional organizations in the United States, and is the principal spokesman for the American business community. The chamber represents 3,800 trade associations and local chambers of commerce. It has a direct membership of over 35,000 business firms and an underlying membership of approximately 5 million individuals and firms.

Over the last several years, the chamber has become increasingly concerned about the welfare problem and about poverty. It has devoted progressively more of its resources to study of these problems, to communications about them with its business members, and to action.

In 1964, the chamber established the task force on economic growth and opportunity. One hundred top business leaders studied the causes of poverty, and made some 80 suggestions for alleviating poverty and strengthening the economy.

In 1965, the chamber published a pamphlet—Welfare Spending: How to Use It Constructively. This described successful experimental programs to help adults on aid to families with dependent children. These included birth control programs, motivation for education, education and job training, and work projects.

The same year, the chamber's council on trends and perspective commissioned and published a study on the prospective demand and supply of manpower for the ensuing decade. One of the manpower potentials analyzed was the adult welfare population.

In 1966, increasing public attention and thought was being directed to better ways and means to provide income to the needy poor. So in December 1966, the chamber sponsored a national symposium on the guaranteed income. The purpose was to provide broad, public exposure of the advantages and disadvantages of a national negative income tax plan. A former member of this Committee on Ways and Means—Congressman Thomas B. Curtis—was one of the five panelists.

In 1966-67, a special advisory panel studied various income maintenance proposals and made on-the-spot investigations of several recruitment, literacy, and training programs for inner city youth and adults, many of whom were on welfare.

As a result of this panel's work, in 1968, the national chamber sponsored a day and a half national workshop on the urban poor—Its manpower and consumer potentials. There were several purposes, but a major one was to show our business members what was being done successfully to help the disadvantaged, the inner city youth, the needy poor—and how to do it. Of course, the objective of these programs was to help these people, including adults on welfare, become employable and placed in self-supporting jobs.

More than a year ago, the national chamber established a committee on welfare programs and income maintenance. The caliber of business leaders who agreed to serve on this is indicated by the membership below:

(The membership referred to follows:)

- M. A. Wright, Chairman, Chief Executive, Humble Oil & Refining Company, Houston, Texas.
- C. E. Allen, Vice President, General Motors Corporation, New York, New York.
- Harlee Branch, Jr., President, The Southern Company, Atlanta, Georgia.
- George Champion, Chairman of the Board, Chase Manhattan Bank, N.A., New York, New York.
- Charles Moeller, Vice President, Metropolitan Life Insurance Company, New York, New York.
- Dennis O'Rourke, Attorney-at-Law, Colorado Springs, Colorado.
- W. Thomas Rice, President, Seaboard Coast Line Railroad Company, Jacksonville, Florida.
- C. G. Drescher, Vice President for Corporate Relations, Sinclair Oil Corporation, New York, New York.
- Gordon Grand, President, Olin Mathieson Chemical Corporation, New York, New York.
- John A. Hill, President, Aetna Life, Casualty and Surety Cos., Hartford, Connecticut.
- A. D. Marshall, President, United Student Aid Funds, Inc., New York, New York.
- Edgar B. Speer, President, United States Steel Corporation, Pittsburgh, Pennsylvania.
- E. Hornsby Wasson, Chairman of the Board, The Pacific Telephone & Telegraph Co., San Francisco, California.
- Walker Winter, Partner, Ross, Hardies, O'Keefe, Babcock, McDugald & Parsons, Chicago, Illinois.

Mr. SCHLOTTERBECK. The major purpose of this committee was to analyze the performance of existing Federal-State welfare programs and to recommend guiding principles for a public income maintenance program to constructively alleviate poverty and, at the same time, preserve human dignity, individual freedom, and personal initiative.

Within the past 2 months, the national chamber cosponsored 1-day urban action forums in 15 cities across the country. In 10 of them, we discussed the AFDC welfare problem with representative groups of business leaders, and suggested ways and means for the local business community to exercise initiative in the development of this manpower potential.

I mention these activities to show that the chamber is deeply concerned about this human problem—welfare—not only about adults in need with children, but also those who are childless. In the course of these activities, we have learned much about these programs, not only those that come before this committee, but others—and also about how much more needs to be known. Nevertheless, it is possible to offer a few guiding principles.

GUIDING PRINCIPLES

Of course, we all know that several million Americans in need are adults and children. The adults either have, or do not have, a work potential. For those needy adults who have virtually no potential for work and self-support—the elderly, the blind, and the disabled—there is a public responsibility to meet their needs. For other needy adults—able-bodied, and with a work potential—occupational rehabilitation is the only constructive, mutually beneficial solution to their problem. For the children in need, we must look to our public educa-

tional and vocational-technical training facilities to prepare them for productive, self-supporting employment in the future.

These are basically the approaches, I believe, of this committee in the 1967 amendments.

The broad approaches for helping people in need obviate the necessity for any national guaranteed income arrangement, such as a negative income tax, or a family or children's allowance program.

We have examined H.R. 14173—the Family Assistance Act of 1969, which was designed jointly by the Departments of Health, Education, and Welfare, and of Labor. We will present our views on major features of the bill under separate headings.

THE ELDERLY, THE BLIND, AND THE DISABLED IN NEED

In general, we support the objectives relating to adults in need who are elderly, blind, or disabled, and the provision for a simplified application procedure, whereby they can apply for help. However, we urge that the Federal financial participation be such that there must be State financial participation as well, whether the average assistance payment in a State is large or small. A joint responsibility of the Federal and State governments in meeting these people's needs can best be assured by joint financial participation all the way.

FAMILIES WITH CHILDREN IN NEED

The chamber heartily commends the objectives of those provisions relating to families in need where the father is absent, or is present and not regularly or fully employed. The objective is to achieve the occupational rehabilitation of the family head. Allowances while in training, and incentives to take a job and to work are sound. The chamber supports these provisions in principle.

Of course, this Committee on Ways and Means pioneered these very constructive ideas in the 1967 social security amendments. This bill proposes to increase some of them.

Other sections of the bill provide for continuation of State financial participation, for free family planning information, and for research, evaluation, and experimentation—continuations of other sound features in the 1967 amendments.

H.R. 14173 would increase the training and job incentives above those in the present law. The need for such increase is not apparent. We understand there is experience in some States indicating that the present incentives are not only effective but may be more than sufficient, and I am sure this committee in executive session will get into finding out about that experience.

If such incentives are effective, we question the need in all circumstances for injecting the element of compulsion, which is provided for in H.R. 14173.

We urge rather promoting an understanding that any "right" of family heads with children in need, to receive welfare from the community embodies a reciprocal responsibility of these adults to the community to avail themselves of public literacy and training opportunities for jobs, so they will become employed and self-supporting.

There is no provision in present Federal-State welfare programs or in H.R. 14173. for constructively helping able-bodied childless adults

in need. We urge similar assistance to such people, except that such welfare payments be conditioned on the applicant's taking training for a job, and then taking a job for which he is qualified. The same training and job incentives should be offered.

Free family planning services should include supplying "birth control devices."

FEDERAL RELIEF FOR THE REGULARLY EMPLOYED

H.R. 14173 provides for a wholly new relief program, financed entirely by the Federal Government. Such relief payments would be made directly to some 2 to 3 million families where the father is present and the family income, after disregarding portions of earned and unearned income, is deemed low in relation to family size.

The National Chamber is opposed to these provisions. They represent the beginning of a national guaranteed income arrangement. A Federal relief subsidy for these fully employed fathers could tend to "lock" them in their present occupations at their present levels of earnings. Such payments could prove to be a strong disincentive to improve their earning capacities.

It is true a few States have decided to help these so-called working poor families. This kind of action should be left to the discretion of each State, and does not justify the Federal Government establishing a national program in all the States. A national program would not be a move in the direction of decentralization, and of greater State responsibility.

RESEARCH AND EVALUATION

Present law and H.R. 14173 provide for research and evaluation—so that welfare, especially AFDC, can be made progressively more constructive in helping people in need. The importance of adequately implementing such congressional intent cannot be overemphasized.

An outstanding authority in social welfare, Dr. Eveline Burns, who has appeared before this committee many times, observed that: "When contemplating the policies that have been applied in the past and considering those which might be applied in the future, it is impossible not to be both impressed and depressed by the extent to which policy decisions are made and perpetuated on the basis of beliefs about facts rather than tested knowledge * * *." ¹

Two proposals in H.R. 14173 will illustrate the significance of Dr. Burns' observation, and of the need for adequate research and evaluation.

H.R. 14173 provides for a nationwide Federal minimum payment of, say, \$1,600 a year to a needy family of four. We are told that this "will eliminate the terrible disparity that now exists between what one State now does for people on welfare, and what another State does which affects the flow of people on welfare from one State to another. And the recent Supreme Court decision banning residency requirements makes it absolutely essential. You've got to have a national minimum standard when you knock out the residency requirements." ²

¹ See Eveline M. Burns, "The Future Course of Public Welfare"—a paper prepared for the 1966 Arden House Conference on Public Welfare.

² See Robert H. Finch, "As I See It"—an interview in *Forbes* magazine, June 15, 1969, pp. 77-78.

This \$1,600 minimum payment in H.R. 14173 is a policy proposal based on a belief about facts—a belief that high AFDC welfare payments have been a major incentive to poor people to migrate to another State solely for the purpose of increasing their welfare incomes or just to get on welfare at pretty good welfare payments for the first time.

The recent study of the sharp growth in the AFDC caseload in New York City, conducted jointly by the Department of Health, Education, and Welfare, and the New York Department of Social Services, concludes that the large welfare payments in New York did not attract people from poor welfare States to New York City. That this was not the explanation for the large growth in New York City caseload.

Between 1960 and 1965, Cook County, Ill., similarly experienced a large growth in its AFDC caseload. A study of the caseload showed that more than 80 percent of the AFDC adults had lived in Illinois from 3 to 36 years before first applying for welfare. This study reached the same conclusion as the New York investigation.

The Supreme Court decision on residency requirements gave rise to a similar belief about facts—that poor people from low welfare States would flock to certain other States and immediately qualify for high welfare payments. Knowledgeable people in one northern State firmly anticipated a sharp and continuing rise in its AFDC caseload. Consequently, they watched new cases carefully, especially those with State residency of less than a year. While there was some increase, it was not great. Moreover, a large number of the new cases had migrated from States which made even higher welfare payments.

A second proposal in H.R. 14173 will illustrate Dr. Burns' observation. This bill would establish a wholly new relief program, covering perhaps twice as many as are on AFDC today. This proposal would pay relief to families of the so-called working poor for the purpose of holding families together.

We know, of course, that in half the States AFDC will not help a needy family if the father is present and unemployed. Moreover, in no State will AFDC help a family where the father is present and regularly employed, but whose earnings are low relative to family size. And in both cases, the family would get more income from AFDC if the father were not present. Hence, it is believed that AFDC over the years has served as a strong incentive toward family breakup—desertion of the family by the father, because the family will financially be better off on welfare. And this explains, some believe, the very great increased growth in the AFDC caseload nationally. In fact, we are told that much of the tremendous growth of AFDC has been due to "father desertions" and is proven by a vast increase in the percentage of the caseload represented by "desertions."

This proposal is also based on a belief about facts.

Proper evaluation of studies made by the Bureau of Public Assistance and by HEW over the past 20 years would disprove this belief. In fact, these studies show that father "desertion" was no greater a factor in 1967 than in 1953, which was the low point in the AFDC caseload for the last two decades.

I think I should explain that something that has happened during the last 20, 25, 30 years. There has been a very great decline in the AFDC caseload for families where the father has died. This is not due to any great improvement in mortality rates, but social security

has moved in and taken care of more of them, and they don't have to go on relief.

Consequently, if you don't adjust the results of these studies for this factor and look at the rest of the caseload you get distorted results.

As a matter of fact, the desertion rate in 1953 after you make this adjustment, was 20 percent in 1953 and in 1967 it was 19.2 percent.

Present knowledge about the various causes—and the timing—of father desertion is probably fragmentary at best. Much more needs to be learned—hard facts—before a sound program could be designed to reduce father desertion. Providing money payments to working poor families might at first glance seem to be an effective means to hold families together. However, a recently completed study, "Families on Welfare in New York City"³ found "most deserted mothers reported that separations from the husbands occurred following the family's first receipt of assistance rather than before."

I suppose one might conjecture from this New York City experience whether the proposed new Federal relief program for the working poor families might initiate more father desertions rather than prevent them.

EMPLOYER INVOLVEMENT

A successful program of training able-bodied adults for jobs will need the continuing active participation and assistance of employers. There is an obvious self-interest involved—employers' present and prospective need for qualified workers. However, adequate facts—hard knowledge—about the AFDC adults are first needed.

Today, there are widespread misconceptions about these people—about their potential to become qualified workers. As a result of your extensive study of the problem in 1967, this committee is probably far better informed than the general public. However, more information is needed about AFDC adults—information about them in each of the 100 to 120 large cities. For it is in these cities where nearly three-fourths of the AFDC families live.

Facts are needed in each such city before employers can effectively and accurately participate and assist in rehabilitation—facts to answer one simple question. What is the manpower potential of these AFDC adults?

In conclusion, Mr. Chairman, the only constructive solution to the problem of able-bodied adults in need is occupational rehabilitation for self-supporting jobs. Appropriate incentives should be built in.

H.R. 14173 incorporates these as basic objectives—as did this Committee on Ways and Means when it developed the 1967 amendments.

We believe there is a great need for hard facts about these people—not only so the problem is better understood, but especially so employers in each community can actively assist in the rehabilitation process. There are two obvious self interests here—of the family head to become trained for a job that will be self-supporting—of employers in obtaining needed qualified workers.

The CHAIRMAN. Mr. Schlotterbeck, we thank you, sir, for your very fine statement. We appreciate your coming to the committee and bringing these views to us.

³ A research study by Prof. Lawrence Podell, financed by an HEW grant. See "Welfare in Review," March–April 1968, U.S. Department of Health, Education, and Welfare.

Mr. Schlotterbeck. I have a question or two I would like to propound. We have had several people testify in the course of these hearings, and other hearings in the past, that the best method of training people for jobs is to get them into "on-the-job training."

Do you agree with that conclusion?

Mr. SCHLOTTERBECK. I am not sure. Mr. Chairman, that I am qualified as an expert in this area. I have seen training programs where they have taken adults on welfare and trained them before they placed them in jobs.

Some employers have told me—and I know that this is true—that they do it, that they take some of these and put them right on the job and train them on the job. I think it may depend upon what the welfare adult comes to the job with. They may need some prejob training.

The CHAIRMAN. I ask you the question because I understand that many of your members have been engaged in the process of trying to train on the job certain people who are or have been on welfare.

Is it just done by the bigger corporations, or is it being done by corporations of all sizes?

Mr. SCHLOTTERBECK. It's probably more likely to have been done by larger corporations, but in the last couple of months I have had the opportunity to get around the country and talk with businessmen in different cities, and a lot of them do have womanpower shortages. And some of them tell me, "If we can just get those who have eighth grade education, we can train them on the job, and we would be glad to do so," because they need workers so badly.

The CHAIRMAN. It has been suggested to us that should we provide for the training of the mothers of children that it would be essential that additional day-care centers be established. In the experience of the corporations that have conducted such training, do they make any arrangements for day-care centers for these mothers?

Mr. SCHLOTTERBECK. Of course, on the day-care centers, I understand that institution is designed for children of preschool age. A lot of these welfare mothers' children will be of in-school age, and that doesn't involve a day-care-center-arrangement. It is afterschool and summer-time care.

I have heard of one or two employers who have provided day care facilities in order to recruit the necessary workers.

The CHAIRMAN. It will be a job, I assume, in your opinion, that will have to be performed by the Federal and State governments or the Federal Government itself.

Mr. SCHLOTTERBECK. I think that may vary. If the Federal Government provides it, why then I suppose no employers would feel they would have to.

The CHAIRMAN. But you don't anticipate a widespread development of day care centers by employers?

Mr. SCHLOTTERBECK. No; I wouldn't anticipate it.

The CHAIRMAN. You have said that your organization does not favor including the so-called working poor in the family assistance benefits. I am not clear whether you would favor including this group in the present AFDC program so that Federal matching funds would be available if a State wished to cover this group in its own program.

Are you suggesting that this be done entirely by the State, or would the Federal Government match these funds, in your thinking?

Mr. SCHNEEBELI. How are they financed? Are they self-financed if they chose to do so.

The CHAIRMAN. I see.

Any further questions?

Mr. Schneebeli.

Mr. SCHNEEBELI. Mr. Schlotterbeck, following up the chairman's discussion of on-the-job training, does the National Alliance of Businessmen, which seems to have done a tremendous job in this area, coordinate their activities with your organization?

Mr. SCHLOTTERBECK. We have a staff person and an advisory panel that works very closely with the National Alliance of Businessmen; yes.

Mr. SCHNEEBELI. How are they financed? Are they self-financed by their own group? They have quite an organization. They have made two very comprehensive reports indicating the job they have done in all areas, in the small business approach as well as large business.

Mr. SCHLOTTERBECK. You are talking about NAB here in Washington or at the local level?

Mr. SCHNEEBELI. Is this financing done by businessmen themselves?

Mr. SCHLOTTERBECK. The company usually donates the services full time of one or more of its staff to an NAB operation in the local community, as they have done here in Washington for the national office staff.

Mr. SCHNEEBELI. That is an on-going organization, I understand.

Mr. SCHLOTTERBECK. Yes.

Mr. SCHNEEBELI. In talking to Mr. Whitney Young yesterday, he was quite high in praise of this group and the very fine job they have done. He also favored on-the-job training, as the chairman suggested. They have already trained, I believe, 140,000 people, which is 40 percent over their objective.

Do they have any goal that they have set now above 140,000?

Mr. SCHLOTTERBECK. I am not that familiar with the NAB goal, Mr. Schneebeli. I couldn't answer your question.

Mr. SCHNEEBELI. Thank you very much, Mr. Chairman.

The CHAIRMAN. Any further question?

Mr. BYRNES. Mr. Chairman?

The CHAIRMAN. Pardon me, Mr. Ullman. If you would be kind enough to yield to Mr. Byrnes, he and I have to go to the Rules Committee in just a few minutes.

Mr. ULLMAN. Yes; I would be very happy to.

Mr. BYRNES. Thank you. I think there is a unanimity of opinion that the real solution to the problem of the able-bodied with a work potential, is to get them trained so that they can fill a job. But that falls short if we don't have job opportunities.

On the problem of bringing the jobs and the people together, I have had a feeling that we have had a void in this area that really the U.S. Employment Service, while it was to some degree intended to do this, has failed in that respect. And part of it, I am inclined to think, is a failure of the employers to adequately use the employment service as a clearinghouse.

I wonder if you would have any comments on that impression that I have. What can we do better, both from a Government standpoint and from the employers' standpoint, in opening up job opportunities

and bringing people with work potential into contact with the available jobs?

Mr. SCHLOTTERBECK. Well, you have put your finger on a problem. There is no doubt about it. You can understand that any employer who is trying to recruit workers is going to recruit them the easiest way he can. And if they have used other methods than the State employment service, it is simply because the other methods have proved more effective.

There is the job bank, which is a relatively new development and was pioneered over in Baltimore. I checked recently with the local chamber of commerce. The job bank has been receiving increasing use by businessmen, particularly for entry jobs. And I understand that there will be many job banks established in cities around the country during this fiscal year.

There probably is a problem of educating employers in these different cities of the utility of the job bank, how it can serve their needs. It will take some time, but I would think that the job bank could become helpful in just the very thing you referred to.

Mr. BYRNES. Of course, this goes beyond just the problems of the poor or the working poor. It goes all through the strata of society. There should be some central point at least where someone out of a job can go to find some idea of what the job opportunities are at that time, and also the same central point for the employers, so that it works both ways. The chamber of commerce, representing the business community and employers, must be concerned about the most effective way of filling vacancies.

I wondered about the degree to which they have focused on this as a situation that could be improved materially for their benefit and the benefit of our working population, even some of the salaried people.

Mr. SCHLOTTERBECK. A lot of employers are in need of workers today, women workers too. Some of them are turning to women to fill jobs traditionally filled by men simply because of manpower shortages. This job bank, if it can be effectively implemented, and the business community in a city can learn about the advantages, will be more broadly used. There is a job of education that we can do on this.

Mr. BYRNES. No matter what we in this committee do here, it just seems to me that all the income maintenance, job training, or work training efforts will go up in smoke unless we get real cooperation on the part of the employer community to gear their employment opportunities into this system.

Mr. SCHLOTTERBECK. You probably are right.

Mr. BYRNES. What can we do to improve mobilization of an effort in this area? One aspect that bothers me is the fact that we don't use more extensively what is in the nature of a job bank. Let's hope that, because it does have some potential, it does grow.

Another factor is the mobility of labor and how you cope with it. For instance, in some of the large cities, job opportunities may be 20 miles or 25 miles away in the suburbs. How do we get those workers to those jobs or get their homes closer? Today, in my area, there are two relatively small communities that I am informed could employ, and are seeking, 800 to 1,000 workers, and these aren't skilled jobs.

I talked to one employer. He said, "I don't even care if they can read or write. I can teach them to do the job that is here. We just don't have the bodies."

Yet, 175 miles away on the upper peninsula of Michigan, there is a high rate of unemployment at the present time. That is of concern to the employers. It is of concern to those people who are unemployed.

These employers are crying, "We need this production. We need these people." And it is needed by the people that are living in a poverty level. Both sides have a real interest here in this mobility problem, and yet I don't see very great attention being paid to the problem. In this society, mobility is one of the factors of life that we have to solve.

Mr. SCHLOTTERBECK. I learned of a somewhat similar situation in Florida, where three businessmen said, "We have had companies come into our cities, small cities, with a view to establishing branch operations, but we don't have the manpower around." And they wanted to know if there was any way where they could persuade some of these black people who had migrated up north for job opportunities to come back home.

Well, I learned about another company in Georgia that had that same problem. They located two families that moved from the Georgia town up north, and they persuaded them to come back home and gave them jobs in this company.

After 2 or 3 months—and they were quite satisfied—they said, "Now, will you write to some of your friends back up North who followed you up North, to come on back home?" And this is the method they are using.

This is slow, but it is the way these people migrated North, and it is the way they are hoping to bring them back home.

Mr. BYRNES. I wonder whether we have to let nature take its course or whether there is something more that needs to be done. We can train people but that doesn't necessarily mean that there is a job opportunity right in that locality within 10 miles of the person's house or 5 miles. It may be 50 miles away. How are we going to get those two together when you get into this distance?

Mr. ULLMAN. Would the gentleman yield?

Mr. BYRNES. Yes.

Mr. ULLMAN. If you will remember in the WIN program, which we set up in the 1967 amendments, we did provide a relocation program. This was turned over to the Department of Labor for administration. It has never been properly implemented.

Mr. BYRNES. I don't think we have ever done it.

Mr. ULLMAN. It has never been implemented, but it is in the law and it could be the beginning of the kind of thing you are talking about.

Mr. BYRNES. Has the chamber addressed itself to this problem in any specific way and come to any conclusions concerning it? If not, might it not be an area that you could study by mobilizing people such as you have on your committee here for welfare programs and income maintenance? Get them to cope with this problem of mobility and of expanding the job bank and getting employer cooperation so that it really is a true bank of job opportunities and people seeking jobs?

Mr. SCHLOTTERBECK. I think we will turn our attention, without question, to the better use of the job bank when they are set up in these cities.

Mr. BYRNES. Thank you very much.

Mr. SCHLOTTERBECK. Thank you.

Mr. ULLMAN (presiding). Mr. Schlotterbeck, I tend to agree with most of your statement, but, unfortunately, you brought us up to the point where the only alternative is to go back to what we did in the 1967 amendments, and I don't think that is a choice of the committee. I fully agree with you that if we go down the road that the administration proposes this is a federalization of the welfare system. And I just don't think it is going to work.

On the other hand, I don't think that we can go back to where we were. I think you sense a feeling of the committee that we feel that industry should be taking a much more active role than it is at present in this whole job-training concept; that it should be a partnership between the Government and industry. And when I talk about government, it has to be Federal, State, and local.

But would you not agree that the administration's proposal would constitute federalization of the welfare program?

Mr. SCHLOTTERBECK. It would seem to be in that direction. But, Mr. Ullman, if I might comment on what you were saying, I commented that there are widespread misconceptions about the adult on welfare, on AFDC. And I could talk for several minutes on that point.

One of the great lacks, one of the reasons business, I think, has done nothing, is because of their misconceptions about who these people are.

When I was talking to some of these business leaders in different cities, they didn't realize, for example, that half of the families on AFDC have no more than one or two children and another 30 percent have only three or four. They didn't realize that roughly three-fourths of the families are headed by women and that 70 percent of them have completed the eighth grade or better. These women are trainable now.

This is all fine to know nationally, but you still have to know what is the manpower potential of the AFDC adults in my city. Until we know something about them, business can't do anything. All you can find out really is you have 15,000 or 17,000 families on AFDC in a given city, and it is costing so much a year.

And in talking with these businessmen I gave them some of this information. Several of them in different cities said, "Why, I never thought that there were potential workers on AFDC." This simply reveals their conception of what these people are like.

Now, until we get a broader knowledge about these adults in these cities, I think it is asking a good deal that business would do anything. In talking with them, I contrasted these mothers with that much education and with small families, with the kind of people they are trying to recruit in NAB—to recruit 18 to 26 and older men.

With them it is hard to find them, a lot of them. Some cities were unable to fill their whole allotment. With the mothers on welfare, the welfare administrator will know where virtually every one of them is. There will be some float, but they will know where most of them are.

So the job of recruitment is vastly simpler.

Another thing is that the mothers, at least three-fourths of them, have attained more education than many of these youths that they are trying to recruit through NAB, so these mothers are more readily trainable.

Finally, the mothers having responsibility for a child or children, they have a sense of responsibility. They will make more responsible and more reliable workers. This has been the experience, incidentally, of some employers around the country with welfare mothers.

So until we get better information about these people out to business, they will continue to have their misconceptions about these people on AFDC.

Mr. ULLMAN. Mr. Schlotterbeck, you know a great deal about the subject, and I don't think in your statement you have gone nearly far enough in giving us answers. But if you were given the problem, assuming that we are not going down the road of the federalized family assistance concept, but that we do have to move forward on, say, a stepped-up program to meet the need because the need is there, what kind of a program would you recommend to this committee?

This is our dilemma. It seems to me we don't have the choice of not doing anything. We must either go the federalization route of the President or else we must renovate this system and insure that we actually meet the problem in the immediate future.

Now, with that challenge, what is your program?

Mr. SCHLOTTERBECK. I couldn't at this moment lay out anything of a blueprint for you, Mr. Ullman. I am not sure I could.

However, I did point out that there are two self-interests—the interest of the adult who wants to work and be self-supporting, and of the employer who needs qualified workers. I think, however, if you amend the existing program, you should try to capitalize on these two very obvious self-interests.

You know, up in Philadelphia there is a program—you have probably heard of it, OIC—and they don't go through any sophisticated testing of the adults that they recruit for their literacy and training. They find them in the neighborhoods, and they ask them one question, "Do you want a job?" If the answer is yes, they say, "Come to us. We will train you."

They have been very successful in this, and they go out into the neighborhood prior to that, trying to motivate these adults, most of whom are on welfare, motivate them to believe they can make it on their own.

But perhaps sometime you and I could talk, and I might have some thoughts.

Mr. ULLMAN. Well, I would hope to talk further with you. You know a lot about this problem, but I don't think you are fully sharing the solutions.

Now, you are aware of the public-assistance grant program under the 1967 amendments, which really has not been implemented. Do you favor the more extensive use of this provision? This would provide for those people who have been trained but for whom there are no immediate jobs. This would tide them over until jobs are available.

Mr. SCHLOTTERBECK. I don't think it is sound to train unless you train for job openings. I think this is a basic principle.

Mr. ULLMAN. I couldn't agree with you more on that. This has been one of my concerns about the manpower training program. I have seen too often where the colleges enter into a training program and train a lot of people for a job. And when they get through with the training program, there aren't any jobs.

This is a rather foolish concept. What we need to do is to get together with industry and find out where the jobs are and get this program integrated. We also need to put Federal, State, and local governments, in my judgment, more actively into the field of job training. We provided for that in the 1967 act.

The unfortunate thing is that we went up and down this road in 1967, and I think we came up with some real long-range constructive answers in the WIN program. But the WIN program has never been implemented to any degree at all.

Now, how do you implement it? Maybe we need to put some more Federal teeth in this thing in order to make sure that it is implemented.

Would you agree to that?

Mr. SCHLOTTERBECK. Perhaps sometime we might talk about this. I am not sure I have any pat answers for you, but I would like the opportunity to do so.

Mr. ULLMAN. We are trying to find answers——

Mr. SCHLOTTERBECK. Yes, I understand that.

Mr. ULLMAN (continuing). From those of you who, I think, have some answers. If you can't do it in testimony, then certainly come to us privately and give us the answers.

Mr. SCHLOTTERBECK. I do want to emphasize that you can't get the business community and employers actively involved unless they have more information in their city about these AFDC adults. I cannot emphasize this too much, because they have misconceptions of what these people are like.

Mr. ULLMAN. If we went into that in a crash program to get the facts, would you be willing on the chamber side to go into a crash program to make available to us some knowledge of the job capacities of industry? I think this is a place where you have a challenge, and I don't see enough being done.

Mr. SCHLOTTERBECK. We would do whatever we could, Mr. Ullman, you can rest assured of that. And we do have a tremendous network of communications and have active members. We would do everything we could.

Mr. ULLMAN. Thank you.

Mr. Conable?

Mr. CONABLE. I would like to ask you this, Mr. Schlotterbeck. There are some limitations on the amount of cooperation we can expect from industry in putting together job banks and things of this sort, aren't there?

It seems to me that we have been assuming that this is a burden that industry is interested in carrying. It also is an opportunity for business. You are looking for good people to work for you, and you are going to have very carefully to design any industry program in the form of a job bank or anything else so as to be completely fair in the equality of the burden you impose and the equality of opportunity you offer on the various employers who participate.

I would like to know where the U.S. Employment Service should fit in here. Also, if you have any evaluation of the efficiency of the U.S. Employment Service, would you let us know?

Mr. SCHLOTTERBECK. I have no evaluation of their efficiency. I couldn't answer you on that. I think the job bank is a real new pioneering idea, and I think we ought to make every effort to make it effective

in the cities where they are going to place it. And I think it can be useful to a lot of employers if the experience in Baltimore is any indication.

Mr. CONABLE. Well, I frequently think that we expect more of industry in these areas than is reasonable under the circumstances. I certainly want to compliment the business community generally on the social concerns they have been expressing recently, particularly with respect to community-oriented efforts.

In my own community of Rochester there has been a particularly enlightened attitude on the part of our business leaders, partly because of the nature of our business, which is quite community oriented.

I wonder, though, if Government isn't trying to fob off on industry in very substantial degree burdens that Government should itself expect to carry simply because we find industry receptive. I think we are sometimes expecting more of industry than industry is designed to deliver. That is a concern I felt as we have talked about industry's role in this.

Mr. SCHLOTTERBECK. You noticed that in my comments here about the adults on welfare I talked in terms of qualified workers. When employers need qualified workers, we can capitalize on their self-interest. I am talking only in terms of qualified workers.

Mr. CONABLE. Thank you very much for your testimony.

Mr. ULLMAN. Are there other questions?

Thank you, Mr. Schlotterbeck.

Mr. SCHLOTTERBECK. Thank you.

(The following statement was received by the committee:)

STATEMENT OF WILLIAM P. McHENRY, JR.,* CHAMBER OF COMMERCE OF THE UNITED STATES

The National Chamber appreciates very much this opportunity to express its views on H.R. 14080, the Administration proposal to make a number of significant changes in our Social Security program. We have carefully studied the various provisions of this bill and urge Congress to:

Approve a 10 per cent across-the-board benefit increase to offset the rise in the cost of living that has occurred since the 1967 amendments;

Increase the amount of "exempt" job earnings under the retirement test from \$1680 to \$1800 a year, as a means of encouraging part-time employment among those elderly who are able to continue working after age 65;

Reject those provisions of the bill calling for *automatic* increases in benefits, *automatic* increases in the taxable wage base, and *automatic* increases in the amount of "exempt" job-earnings;

Finance the across-the-board benefit increase and other proposed changes from the projected long-range "actuarial surplus"—the excess of "tax take" over costs;

Postpone the timing of presently scheduled tax rate increases for the Social Security cash benefits program to prevent unnecessary growth in the trust funds;

Advance the timing of presently scheduled tax rate increases for the Medicare (Hospital Insurance) program to reduce the long-range "deficit" in this program;

Maintain the taxable wage base at its present level of \$7800 per year.

We will analyze the reasons for these recommendations in subsequent sections.

THE COST-OF-LIVING BENEFIT INCREASE

Since February, 1968, (which was the effective date of the last benefit increase) and September, 1969, the general price level as measured by the Con-

*Senior Associate, Human Resources Development Group, Chamber of Commerce of the United States.

sumer Price Index has risen almost 9 per cent.¹ Doubtless, the cost of living will be somewhat higher than it is today by the time Congress completes action on a bill.

Section 2 of the bill would initiate a 10 per cent across-the-board increase for all present and future beneficiaries effective March, 1970. During the first full calendar year of operation, an estimated \$3 billion in extra benefits would be paid out to 25½ million beneficiaries.

The National Chamber supports a 10 per cent increase to offset the rise in the cost of living since the 1967 Amendments. These higher benefits should be made available to Social Security beneficiaries as soon as practicable.

INCREASING THE AMOUNT OF EXEMPT EARNINGS—THE RETIREMENT TEST

Social Security benefits are intended to provide a partial replacement of a worker's job-income loss when earnings are cut off because of age, total and permanent disability, or death of the breadwinner.

The amount of "exempt" earnings—the so-called retirement test—is a condition of eligibility for cash benefits. This provision enables Congress to determine whether a beneficiary is substantially retired from the labor force or is continuing to support himself by working regularly.

Under present law, a beneficiary can earn \$1680 a year—\$140 a month—and still receive all his benefits. For earnings between \$1680 and \$2880, \$1 in benefits is withheld for every \$2 of pay. If a worker makes more than \$2880, withholding is \$1 for \$1. In other words, the withholding provisions are equivalent to a 50 per cent tax on earnings between \$1680 and \$2880 and to a 100 per cent tax on earnings above that amount.

H.R. 14080 would make three significant changes in present law:

The annual amount of "exempt" earnings would be increased from \$1680 to \$1800 in 1971;

The 100 per cent tax on earnings above \$2880 per year would be eliminated; The annual amount of "exempt" earnings would be automatically increased, beginning in 1972, as average wage levels rise.

The National Chamber supports the increase in the annual "exempt" amount from \$1680 to \$1800 and the elimination of the 100 per cent tax aspect. This change would help encourage part-time work among the relatively few elderly persons who are affected by this condition of eligibility.²

On the other hand, we oppose any proposal calling for *automatic* increases in the annual "exempt" amount under the retirement test. Since 1950, Congress has raised the annual amount of "exempt" earnings five times—from \$600 in 1951 to \$1680 under the 1967 amendments. These increases were made only after careful study of relevant factors.

Any further changes in the so-called retirement test should be made only after considering such factors as prevailing retirement practices in industry and whether there are manpower shortages. The National Chamber recommends that the automatic adjustment feature be deleted from the bill.

AUTOMATIC INCREASES IN BENEFITS AND TAXES

H.R. 14080 proposes, beginning in 1971, that benefits be automatically increased to offset the effects of inflation. In the future, benefits would be raised whenever the price level, as measured by the Consumer Price Index, increased by at least 3 per cent. No more than one automatic increase would be permitted each year.

The Administration contends that a cost-of-living escalator is needed because:

1. the "uncertainty of adjustment under present laws and the delay often encountered when the needs are already apparent is unnecessarily harsh . . ." on beneficiaries;

¹ Between February, 1968, and September, 1969, the Consumer Price Index (1957-59 = 100) rose from 119 to 129.3 or by 8.7 percent. Source of data: Bureau of Labor Statistics, U.S. Department of Labor.

² According to the Social Security Administration, "Analysis of the effect of the retirement test on older people indicates that 90 percent of the people eligible for benefits are probably not affected by the test because they are 72 or older or are unable or unwilling to work to any substantial degree. Thus, any change in the test, including its elimination, would not help at all the vast majority of people who are eligible for benefits; the people who would benefit from elimination or liberalization of the retirement test would be those who continue working and earning relatively substantial incomes." See U.S. Department of Health, Education, and Welfare, *The Retirement Test Under Social Security*, Report on a study called for by the Congress in Public Law 90-248 (the Social Security Amendments of 1967), January 9, 1969, page 9.

2. An automatic feature would “. . . depoliticize, to a certain extent, the Social Security System . . .”³

In order to finance this benefit escalator, H.R. 14080 proposes *automatic* increases in the taxable earnings base—that is, automatic increases in the amount of a worker's pay that is taxed by Social Security. This change would be effective in 1974.

In consequence of this provision, the proposed base of \$9000 would be automatically increased in the future in accordance with the increases in average wages. The effect of this proposal would be not only to raise the taxable earnings base but also automatically increase taxes on employers and on some workers in the future.

The National Chamber is opposed to any proposals to automatically increase benefits and taxes. First, the record shows that Congress has kept benefits up-to-date so an automatic adjustment isn't needed. Second, an automatic wage base escalator means that workers and employers would never know in advance their total tax liability for Social Security. This is unsound and should be rejected.

The record on benefit increases

The record shows that Congress has regularly reviewed the Social Security program and made numerous improvements. Benefit protection and tax coverage have been extended to new occupations, benefits have been made larger and easier to get, and new kinds of benefits, such as Medicare, have been added. As Table 1 on page 6 shows, the benefit increases approved by Congress between December, 1964 February, 1968 have more than offset the effects of inflation.

Periodic review of *all* aspects of the program is the only sound course to follow in considering changes in Social Security. The record shows that Congress has done a commendable job of keeping benefits, and other features of the program up-to-date with changing economic and social conditions. There is no mutual advantage of an automatic benefit and tax escalator for Social Security beneficiaries, and for the millions of workers and thousands of employers who must pay the taxes to finance benefits. The National Chamber recommends that these proposals be rejected.

Automatic increase in the taxable wage base

The National Chamber regards the proposal to automatically increase the taxable wage base as unnecessary and unsound.

The major reason this provision is included in the bill is to finance automatic benefit increases. If the automatic benefit escalator is eliminated as we recommend this means there is no need for an automatic wage base increase.

Automatic wage base increases would also initiate a new and dangerous principle for Social Security: an unknown future tax cost commitment for the program.

Each time Congress has enacted changes in Social Security, workers and employers have known precisely how much in future taxes they would be required to pay to support the program. Thus, under today's law, every worker earning at least \$7800 and his employer knows that his yearly taxes for Social Security and Medicare will increase in steps from \$374 each in 1969 to \$460 each by 1987. During the same period, the annual tax on self-employed is scheduled to increase from \$538 to \$616.

However, under H.R. 14080, the future tax burden would be most uncertain. All the \$9000 a year worker, and his employer, would know is that their taxes may increase above \$459 after 1972.

The future tax burden on those who support the program should not be left in such an indefinite and uncertain state. This proposal should be rejected.

³ The White House, *Message on Social Security*, September 25, 1969, page 2.

TABLE 1.—INCREASE IN THE COST OF LIVING COMPARED WITH INCREASE IN AVERAGE SOCIAL SECURITY BENEFITS BETWEEN DECEMBER 1954 AND FEBRUARY 1968¹

Year and month	Consumer Price Index ²	Cumulative increase (percent)	Average monthly benefit of retired workers	Cumulative increase (percent)
December 1954.....	³ 100.0	-----	⁴ \$59.14	-----
January 1959.....	108.3	8.3	63.28	7.0
January 1965.....	116.8	16.8	67.71	14.5
February 1968.....	127.7	27.7	76.51	29.4

¹ 1954 was picked as the base year for comparison because it was not until then the proportion of aged social security beneficiaries who were also receiving old-age assistance—public welfare—dropped below the 10-percent standard of benefit adequacy recommended by the first Commissioner of Social Security, Arthur J. Altmeyer.

² December 1954=100.

³ Consumer Price Index (1957–59=100) converted to 1954 base.

⁴ Data for 1954 obtained from U.S. Department of Health, Education, and Welfare, Social Security Bulletin, Annual Statistical Supplement, 1967, table 12, p. 21.

Note: Since 1954, Congress has enacted 3 across-the-board benefit increases—7 percent under the 1958 amendments (effective in January 1959); 7 percent under the 1965 amendments (effective in January 1965); and 13 percent under the 1967 amendments (effective in February 1968).

FINANCING SOCIAL SECURITY AND MEDICARE

Present law calls for periodic increases in tax rates to finance the cash benefits program and Medicare. Tax rates on *each* employee and employer for cash benefits rise from 4.2 per cent this year to 4.6 per cent in 1971 and to 5.0 per cent in 1973. Medicare tax rates increase, in steps, from 0.6 per cent in 1969 to 0.9 per cent in 1987. Combined tax rates to pay for both programs do not exceed 5.9 per cent on *each* employee and employer on a taxable earnings base of \$7800.

Financing cash benefits

Scheduled tax rate increases are expected to generate substantially more revenue than is needed to meet obligations over the long-run. Projected "tax take" from workers and employers will exceed benefit payments and administrative expenses by a wide margin according to the Social Security Chief Actuary.⁴ Moreover, on a short-range basis, there is a very substantial build-up in the trust funds—much more than is needed to maintain a contingency reserve and keep the program on a pay-as-you-go basis. Between Fiscal Year 1970 and 1973, the trust fund will increase from \$39 billion to \$75 billion. The balance in fiscal 1973 will be sufficient to pay benefits for 28 months as compared with 16 months in fiscal 1970.

The expected excess of "tax take" over outgo is adequate to finance the 10 per cent benefit increase and other improvements called for in H.R. 14080 (exclusive of the automatic features) *without* any increase in taxes on workers and employers. In other words, it is possible to finance these changes without increasing presently scheduled tax rates above 5.0 per cent or the taxable wage base above \$7800.

The National Chamber recommends that Congress finance the 10 per cent benefit increase, and the other changes proposed by H.R. 14080, from the expected excess of "tax take" over outgo. If Congress increases benefits in excess of what can be handled from the long-range "actuarial surplus," then tax rates should be increased to maintain the cash program on a financially sound basis.

To prevent the unnecessary growth in the size of the trust funds, H.R. 14080 properly postpones the timing of presently scheduled tax rate increases. The Ways and Means Committee has stated that there should be about one year's benefit payments in the trust fund. The National Chamber agrees that this is a reasonable principle to follow and recommends that Congress schedule future tax rate increases to accomplish this objective.

Financing medicare

Medicare (hospital insurance) is out of "actuarial balance" again. The Social Security Chief Actuary, Mr. Robert J. Myers, expects outgo to exceed "tax take"

⁴ The Social Security Chief Actuary, Robert J. Myers, has recently completed new cost estimates for both the cash benefits and Medicare programs. These new cost estimates show that the cash benefits program has a "positive" actuarial balance of +1.16 percent of taxable payroll. Conversely, the Medicare program is out of balance by a wide margin. Benefit payments and administrative expenses are expected to exceed tax revenue by -0.77 percent of taxable payroll. See, *Summary Results of New Cost Estimates for Present OASDI and HI Systems and for President's Proposal*, a Memorandum submitted to Mr. Robert M. Ball, Commissioner of Social Security, September 25, 1969.

by a very wide margin.⁵ He estimates that a 50-percent increase in tax revenue is needed to close the gap between outgo and income. Without additional taxes the medicare trust fund will be exhausted in fiscal year 1973.

The major reason for the continuing financial difficulty of medicare is the very rapid increase in hospital costs.

H.R. 14080 proposes to correct the financing problem by moving the medicare tax rate forward 16 years—0.9 percent rate would be effective in 1971 rather than 1987—and apply this higher rate to a \$9,000 taxable wage base. Moreover, in the future, additional tax money would be channeled into the medicare program on a *continuing* basis via *automatic* increases in the taxable wage base beginning in 1974. The administration believes that these actions will eliminate the deficit and keep medicare on a financially sound basis—that is, revenue will slightly exceed outgo—over the next 25 years.

The first 3 years' experience with medicare confirms our earlier conviction that the future costs of a program paying for services cannot be estimated reliably. So long as the program continues to pay for services, workers and employers must expect to pay higher taxes in the light of unfolding experience.

The facts show that the medicare (hospital insurance) program needs additional financing. The National Chamber is opposed to any increase in the taxable wage base, automatic or otherwise, to accomplish this objective. Instead, we recommend advancing the medicare tax rate from 0.6 percent to 0.9 percent in 1971. This will reduce the deficit by 35 percent and provide enough revenue to operate the program for at least 5 more years.

Table II on page 10 compares social security and medicare tax rates under present law with the substantially revised schedule proposed by H.R. 14080.

TABLE II.—SOCIAL SECURITY AND MEDICARE TAX RATES—PRESENT LAW COMPARED WITH H.R. 14080

[In percent]

Year	Present law			H.R. 14080		
	Cash benefits	Medicare	Total	Cash benefits	Medicare	Total
1970.....	4.20	0.60	4.80	4.2	0.60	4.80
1971-72.....	4.60	.60	5.20	4.2	.90	5.10
1973-74.....	5.00	.65	5.65	4.2	.90	5.10
1975.....	5.00	.65	5.65	4.6	.90	5.50
1976.....	5.00	.70	5.70	4.6	.90	5.50
1977-79.....	5.00	.70	5.70	4.8	.90	5.70
1980-86.....	5.00	.80	5.80	4.9	.90	5.80
1987 and after.....	5.00	.90	5.90	5.0	.90	5.90

INCREASING THE TAXABLE WAGE BASE

Section 6 of H.R. 14080 proposes to increase the present taxable wage base—the amount of the worker's pay that is taxable by social security—from \$7,800 to \$9,000 per year effective in 1972.

Since 1950, the taxable wage base has been increased five times—from \$3,600 in 1951 to \$7,800 today. When Congress increased the taxable wage base to \$7,800 in 1968, it was about \$1,200 higher than the average earnings of the year-round male worker covered by social security. The \$7,800 wage base was \$4,200 larger than the average earnings of regularly employed women.

As table III shows, the present taxable wage base is still well above average earnings of year-round workers covered by social security. Any increase in the \$7,800 wage base is not justified at this time.

⁵ See footnote reference on page 7.

TABLE III.—COMPARISON OF SOCIAL SECURITY TAXABLE WAGE BASE WITH MEDIAN ANNUAL EARNINGS OF REGULARLY EMPLOYED WORKERS 1960-72¹

Year	Taxable wage base	Median annual earnings	
		Men	Women
1960.....	\$4,800	\$4,837	\$2,706
1961.....	4,800	4,950	2,776
1962.....	4,800	5,139	2,876
1963.....	4,800	5,298	2,956
1964.....	4,800	5,530	3,090
1965.....	4,800	5,740	3,180
1966.....	6,600	6,090	3,330
1967.....	6,600	6,340	3,450
1968 ²	7,800	6,594	3,571
1969.....	7,800	6,858	3,696
1970.....	7,800	7,132	3,825
1971.....	7,800	7,417	3,959
1972.....	7,800	7,714	4,098

¹ U.S. Department of Health, Education, and Welfare, Social Security Bulletin, Annual Statistical Supplement, 1967, table 35, p. 41. "Regularly Employed Worker" refers to 4-quarter wage and salary workers covered by Social Security.

² Data estimated from 1968 through 1972. Projected annual increase in median earnings based on experience from 1960 through 1967.

Mr. ULLMAN. Our next witness is Dr. Whiting.

Dr. Whiting, we are glad to have you before the committee again.

Would you please identify yourself and your colleagues for the record, and proceed as you see fit, sir.

STATEMENT OF DR. HENRY J. WHITING, SECRETARY FOR SOCIAL RESEARCH AND PLANNING, DIVISION OF WELFARE SERVICES, LUTHERAN COUNCIL IN THE UNITED STATES OF AMERICA; ACCOMPANIED BY DR. ROBERT VAN DEUSEN, DIRECTOR, OFFICE OF PUBLIC AFFAIRS, LUTHERAN COUNCIL IN THE UNITED STATES; AND REV. RUFUS CUTHBERTSON, ASSOCIATE SECRETARY, BOARD OF SOCIAL MINISTRY, LUTHERAN CHURCH IN AMERICA

Dr. WHITING. Yes, sir.

Mr. Chairman, I am Henry J. Whiting, secretary for social research and planning, Division of Welfare Services, Lutheran Council in the United States of America. Associated with me in this presentation, on my right is Dr. Robert Van Deusen, director, office of public affairs of this council; and the Reverend Rufus Cuthbertson, on my left, who is associate secretary for the Board of Social Ministry, of the Lutheran Church in America.

Mr. ULLMAN. We welcome you gentlemen before the committee also.

You may proceed, sir.

SUMMARY

Some Comments on Proposed Amendments to the Social Security Act

I. The present governmental social assistance programs are in need of critical review and revisions so that the cycle of poverty may be broken and the poor enabled to become full participants in the privileges and responsibilities of society. In such review, consideration should be given to the following:

1. Elimination of the categories in the social assistance program and establishment of the single criterion of financial need.

2. Adequate provisions for insuring incentives in moving off public assistance for those for whom this is possible.

3. Inclusion of the working poor with exemption of graduated levels of earned income and careful attention given to protection against any possible support of inadequate wages.

4. Provision of a basic floor of financial benefits by the federal government at an adequate level for health and decency.

5. Development of effective job training programs and related services such as day care centers, homemaker services, family planning, health maintenance, and vocational counselling.

6. Assurance that a mother with sole responsibility for her children will not be required to accept employment against her own best judgment as to that which is best for the welfare of the children.

7. Protection against possible abuse of mandating employment by forcing acceptance of jobs which offer no constructive opportunity for development or which are not consistent with the worker's abilities.

II. Strengthening and Extending Social Insurance Program.

III. Development of Comprehensive Social Services.

IV. Improving Mechanisms for Federal, State and Local Cooperation in the Planning and Maintenance of Program.

V. Standards for Public Social Security Programs.

VI. Development of Social Research.

Dr. WHITING. This testimony is submitted by the Lutheran Council in the United States of America at the request of and on behalf of the duly authorized officers of its participating bodies which include—

	<i>Membership</i>
The American Lutheran Church-----	2,567,027
Lutheran Church in America-----	3,288,037
The Lutheran Church-Missouri Synod-----	2,847,425

This council was organized in 1966 and has among its functions, as stated in its constitution:

"To represent the interest of the Council, and the interests of a participating body so requesting in matters which require common action before * * *

"(2) the national government * * * ."

FOREWORD

CONTINUING VALIDITY OF INDIVIDUAL, VOLUNTARY ASSOCIATION AND GOVERNMENTAL EFFORT

Throughout the history of our Nation, we Americans have developed three broad types of response to people in need, namely, individual, voluntary associational, and governmental.

In the days of colonization, and, indeed, also as pioneers and new immigrants pressed the westward expansion of the country, the hazards and hardships of life made necessary the neighborly response of one individual to another individual's need. Without such neighborly assistance, life would have been intolerable and survival impossible.

As ever larger groups of people gathered together into towns and cities, individuals banded themselves together into voluntary associations for mutual protection and assistance. Such associations were generally established upon one or the other of a number of different bases, among which the more common were religion, nationality, labor, business, and fraternal orders.

Government has also responded to the needs of people from the earliest days of settlement. Beginning with the colonial governments, towns, cities, counties, States, and later the Federal Government itself, each filled important roles in the broad field of social welfare.

In this testimony, we wish to affirm the continuing validity and the necessary presence of each of these three basic forms of response to people in trouble in a free democratic society—individual, voluntary association, and government.

SOME COMMENTS ON PROPOSED AMENDMENTS TO THE SOCIAL SECURITY ACT

We very quickly sought the opportunity to present testimony on this proposed legislation for we have a conviction that the action taken by Congress will be of deep significance to the well-being of millions of our fellow Americans who are daily experiencing the grinding pain of deprivation and poverty.

We, therefore, place before you some judgments and comments on this critically important subject.

I. NEED FOR REVIEW OF PRESENT PROGRAMS

First of all, the need for review of present programs:

The present governmental social assistance programs are in need of critical review and revisions so that the cycle of poverty may be broken and the poor enabled to become full participants in the privileges and responsibilities of society.

It is well known, Mr. Chairman, that out of all the Nation's poor, the Federal Government has selected for financial assistance only those who match certain defined categories: the aged (old-age assistance); blind (aid to the blind); disabled (aid to the permanently and totally disabled); children (aid to families with dependent children). It is true that States and local governmental units have developed programs of general assistance but this represents only a fraction of the total need. For each of these programs, there are separate and distinct eligibility requirements and each State and territory has established its own program policies within the framework of Federal and State laws.

One tragic result of this categorical approach to human need is that many of the Nation's poor are completely neglected or receive minimum assistance. How can we select only certain groups in our society as somehow more worthy of assistance than others whose need may well be just as crucial and hurtful?

Moreover, the present programs of public assistance in order to conform to legislation enacting the programs and providing budgetary support have set up a maze of administrative procedures and practices to be followed by staff in establishing eligibility, checking resources, approving requests for special grants, et cetera, so that little time remains for giving supportive, protective, and rehabilitative service. It must not be overlooked that such administrative procedures represent substantial dollar costs—part of which dollars could likely be more helpfully used in money grants or services to persons in need of them.

It is recognized that many persons presently on the rolls of public assistance will undoubtedly have to continue to look to society for financial assistance. Any prospect of being able to get off public assistance rolls through rehabilitative services is undoubtedly quite remote if not impossible. This is particularly true of the aged, the handicapped, and the disabled. The demands of our mechanized, industrialized society make their participation in the economy through

employment quite unlikely. In the case of the AFDC, it is possible that through genuine family assistance plans, particularly if the employed poor and unemployed were included with adequate grants, the poverty cycle could be broken.

As the present public assistance program is reviewed and revisions are proposed, we urge that consideration be given in the following program elements:

1. Elimination of the categories in the social assistance program and establishment of the single criterion of financial need.
2. Adequate provisions for assuring incentives in moving off public assistance for those for whom this is possible.
3. Inclusion of the working poor with exemption of graduated levels of earned income and careful attention given to protection against any possible support of inadequate wages.
4. Provision of a basic floor of financial benefits by the Federal Government at an adequate level for health and decency.
5. Provision of effective job training program and related services such as day care centers, homemaker services, family planning, health maintenance, and vocational counseling.
6. Assurance that a mother with sole responsibility for her children will not be required to accept employment against her own best judgment as to that which is best for the welfare of the children.
7. Protection against possible abuse of mandating employment by forcing acceptance of jobs which offer no constructive opportunity for development or which are not consistent with the worker's abilities.

II. STRENGTHENING AND EXTENDING SOCIAL INSURANCE PROGRAM

The second major portion of our testimony, Mr. Chairman, is to express the need to strengthen and extend the social insurance program with respect to persons not now included and benefits paid.

Certainly the present social insurance program has proved itself to be an effective instrumentality by which government, employer, and employee can enter into a partnership for preparation against certain hazards of life. In a very real way, it is a first line of defense in warding off poverty which formerly resulted from illness, disability, unemployment, and old age, and we believe it ought to be even more extended.

We must, however, review this program and make necessary adjustments from time to time so that it may continue to serve the people of this Nation.

The critical problem faced by persons who are dependent on a fixed income, such as a pension, during a period of rising prices is well known. Steps should be taken immediately to raise the minimums to reasonable levels and to increase the benefits. We note with satisfaction that there is near general support for such an increase with debate centered only on the amount. We urge Congress to provide the maximum possible within the framework of the present and potential resources of the program.

In this connection, we do applaud the efforts to tie the benefit schedule to the cost of living. If provision could be made for such automatic adjustments, it would help to give genuine security to older citizens who presently are restricted to a fixed income. Related here

are two other proposals which merit general support, namely, (1) an increase in allowable earnings without reduction of benefits, and (2) an increase in the wage base for computing the tax in order to keep the benefits in relation to earnings as well as to protect the fiscal soundness of the program.

Although the great majority of workers are now included in the program, there remain some who are excluded. We urge Congress to continue to provide for the inclusion of additional classifications of workers. Society must stand by and provide protection for the citizen against those risks which arise in the social system.

THE DEVELOPMENT OF COMPREHENSIVE SOCIAL SERVICES

Comprehensive social services should be developed and made readily available to those in need with full consideration given to programs of public agencies and those under private auspices.

We recognize, Mr. Chairman, that the legislation on which hearings are now being held, deal essentially with income maintenance programs through the mechanisms of social insurance and public assistance. Nevertheless, we believe that any discussion of income maintenance should include some reference to the relationship of such programs to others dealing with social services. We believe that these two essential programs under public auspices should be so structured and administered that where the client needs social services along with income maintenance, he can secure them but in those instances where the need is for the one and not the other, he can receive that which he needs. Financial need may or may not be related to personal or family problems. The person whose essential need is financial should be free to come to a public welfare agency and receive consideration with respect to that need and that need alone. He should not be placed in a position of being expected to accept a social service when, in his mind at least, his need is exclusively for a money grant.

Then there are persons in our communities who need social services but who have no money needs. Many individual and family problems occur without any relationship to money needs, and persons with such difficulties should be able to secure the social services they need.

But there are persons who require financial assistance and special services concurrently, and these needs are interrelated. Such persons, notably the aged, the handicapped, and children in families undergoing crisis should get the help they need.

We believe that voluntary agencies continue to perform valuable services to people in trouble and that there will always be a significant role for such voluntary agencies in a free democratic society. We also believe that government, since it alone has the requisite massive resources and structures, has a fundamentally requisite role to play. As governmental programs are developed, full attention should be given to existent and potential services available under voluntary auspices.

Much study needs to be given to ways by which we can improve the organization and delivery systems by which a comprehensive system of social services is made available to people. As plans are developed for comprehensive service programs, the interrelationships between governmental and voluntary agencies should be clarified and strengthened and provision made for the ready availability of social services to people when and where they are needed.

IV. IMPROVING MECHANISMS FOR FEDERAL, STATE, AND LOCAL COOPERATION IN THE PLANNING AND MAINTENANCE OF PROGRAMS

Federal, State, and local governments all have necessary roles to play in the development and maintenance of adequate social welfare programs but there is need for improvement of the mechanisms by which these units plan, formulate, and administer such programs and for the more equitable distribution of natural and economic resources to support them properly throughout the entire Nation.

Since the inauguration of the social security programs in the 1930's, there has emerged in this country a partnership of Federal, State, and local units in providing social assistance programs to people. Though we affirm the continuing validity of such a partnership, we must also recognize the need to continually study and review the arrangements by which these governmental units plan, develop, and administer effective social welfare programs.

We are now at the time where we are able to define and articulate broad goals for human and social development in our society and to develop concrete steps toward their attainment.

The increasing mobility of our people, the varied economic resources among the regions of our Nation, and the interrelatedness of many problems throughout the country place upon the Federal Government an inescapable responsibility for leadership and for provision of necessary resources. We note with approval the growing assumption of this responsibility by the Federal Government. The Federal Government should use its broad taxing power to bring about a greater degree of equality among the States in funding social welfare services and financial grants to those in need. All Americans are citizens of this Nation and none should be denied or limited in their struggle to realize their full potential because of the circumstances of birth or residence in a particular geographical region.

V. STANDARDS FOR PUBLIC SOCIAL SECURITY PROGRAMS

Standards for public social assistance, social insurance, and social service programs should be developed and enforced by the Federal Government.

As the Federal Government, in cooperation with the States, sets broad social goals, and mobilizes and distributes the fiscal resources of the Nation equitably, it follows that it must also responsibly exercise its role in the development of national standards.

A national standard of public assistance payment, adequate for health and dignity, below which no State may fall should be established and the present wide range of public assistance among the States and territories should be corrected. We note the administration's proposals on welfare provide for a floor of \$1,600 in the family assistance plan and \$90 monthly in the adult categories. We express the judgment that these proposed minimum grants are excessively low and urge that consideration be given to placing them at a higher level consistent with health and decency. Although consideration is being given to extending the food stamp program which if put into effect would bring some measure of relief to the poor, we believe that this should be undertaken only as a diet supplement program and not be a substitute for adequate money grants.

It should also be noted that the diversity and range of public assistance payments represent both variation in economic capacity among the States, indeed a critical factor, and prejudicial attitudes toward the poor which are too often present. Payments by many States are tragically low and in many cases even below that which the State itself has established as its own standard level.

In considering the proposals for developing the family assistance plan, every effort should be made not only to assist the poorer States but also to devise means by which the several States can be encouraged to move beyond the national floor which is to be established. Just as the proposed legislation recognizes the need to encourage the recipient who has the potential to work his way out of poverty by setting up earnings exemptions, so it should develop a system for encouraging the States to raise their levels of participation in meeting the needs of the poor.

But standards of program operation are also necessary. Programs should be operated in such a way that the rights, dignity, and personhood of all people in our Nation are recognized and accepted without regard to race, color, creed, residence, or circumstances of birth.

Manpower in adequate numbers and competence is the essential base upon which the necessary programs to help people must rest. Standards dealing with the procurement and maintenance of personnel in public welfare programs are critical, for without skilled and competent staff programs necessarily operate at minimal, largely ineffective levels.

VI. THE DEVELOPMENT OF SOCIAL RESEARCH

The resources of Government should be utilized in more extensive development of research in social welfare.

We note with genuine approval that the proposed legislation authorizes the Secretary of Health, Education, and Welfare to conduct research into or sponsor demonstrations of ways of better carrying out the purposes of the family assistance plan. We fully support this program and urge financing at levels commensurate with the need for them.

It is critically urgent that resources of Government be made available to provide leadership and funds for the development of research in social welfare. Science, industry, communication, and other fields are devoting vast resources to research. But in the field of social welfare, an area committed to the well-being of the Nation's children, youth, families, and aged, the provision for research has always been minimal.

With the resultant knowledge in causative factors in individual and family breakdown, dependency, antisocial behavior and other related personal and social ills, society will be the better equipped to develop protective, preventive, and rehabilitative services to individuals as well as those social measures designed to deal with such problems. As we seek solutions to such problems as poverty and dependency, we need more research to assist in pointing the way to new forms and patterns for helping people in trouble and keeping them out of trouble.

In conclusion, we affirm the need of this Nation to rise to a new level of moral commitment to the well-being of all its citizens. People are the Nation's most precious resource and their welfare must be

our first priority. All Americans wherever they live in this land, whatever their circumstances of birth, their social situation—children, the poor, the deprived, the aged, the handicapped—all should be enabled to walk in dignity and peace as responsible participating members of our national community.

Now, Mr. Chairman, if I may, my colleague, the Rev. Rufus Cuthbertson, has a statement which he should like to make also for the record.

Mr. ULLMAN. We are glad to recognize you, sir.

Reverend CUTHBERTSON. Mr. Chairman, I would like to say that I find myself in agreement with the statement which Dr. Whiting has made and that I have a particular interest in being here with him. The staff of the Board of Social Ministry of the Lutheran Church in America, of which I am a member, has the responsibility of implementing the positions which the Lutheran Church in America has taken.

The Lutheran Church in America has taken a position in its statement on poverty adopted in 1966, and in its statement on the church and social welfare adopted in 1968, which gives the Board of Social Ministry a mandate to seek to implement these statements within the constituency of the church. Therefore our particular interest in this legislation, for we see this legislation as a step in the direction of the implementation of some of the things which the church has said in convention.

I would like to call attention to one paragraph of the 1966 statement of the Lutheran Church in America on poverty, which speaks to our concern about legislation of this sort, and I quote:

We believe that in nations where conditions of abundance exist, it should be the goal of the national economy to provide every able-bodied adult with the opportunity for meaningful employment sufficiently remunerative to secure, at the very least, the minimal necessities required in our society for living in decency and dignity. Further, where a full employment economy is not possible or not desirable, or where individual inadequacies exist, we believe our countries have the responsibility to move as readily as possible to assure income adequate to secure the minimal standard of living.

This is a part of a statement adopted, as I say, by the convention of the church which is a representative assembly with equal representation of clergy and laymen from across the country, an assembly of some 700 persons which meets biennially to consider the interests of the constituency of the Lutheran Church in America, a constituency of some 3 million persons.

In implementing this statement of the church, we have, since May of this year been engaged in an intensive effort within our constituency to generate concern for improvement in the area of welfare legislation and this is why I am appearing here with Dr. Whiting.

Dr. VAN DEUSEN. I might add, Mr. Chairman, that Mr. Cuthbertson has with him a supply of 75 copies of the total statement from which he read, and we will deposit that statement with the committee office room so that it can be included in the record.

(The statement referred to follows:)

SOCIAL STATEMENTS OF THE LUTHERAN CHURCH IN AMERICA

POVERTY

(Adopted by the Third Biennial Convention, Kansas City, Missouri,
June 21-29, 1966)

Justice for the impoverished and dispossessed has been the concern of the people of God under both the Old and New Covenants. Under the divine imperative of prophetic faith, Christians today continue to seek justice for all whose lives are subject to abject poverty. Under the abundant mercy of the Father of Our Lord, Jesus Christ, Christians are constrained to minister compassionately to the needs of all their neighbors. Motivated by the love of God in Christ, the church has this double commission: to serve human need and to testify prophetically for justice in the ordering of society and the use of its resources.

Poverty is an age-old affliction of the human race. Concern for the poor, both through the economic arrangements of society and through the expression of personal responsibility, is a continuing theme throughout the Old and New Testaments. Today we find ourselves confronted by a radically new and potentially explosive situation in human society. On the one hand, the population explosion and modern technological developments threaten to create a class of human beings who are economically superfluous, and who find themselves increasingly sealed off from participation in the economic benefits of society.

On the other hand, the revolution in technology holds out, for the first time in history, the possibility of the virtual elimination of hunger and basic economic deprivation both at home and throughout the world. The contrast between plenty and poverty, on the domestic and on the world scene, becomes doubly scandalous in the light of this new possibility.

The possibilities for good inherent in God's new gifts to mankind in technology will not be realized without changes in some attitudes and in some economic arrangements. Today's situation presents vastly new dimensions of justice and confronts serving love with opportunities hitherto undreamed of. Realizing that no conclusive word can yet be spoken about new forms of social and economic order, or even of proper attitudes underlying them, the Lutheran Church in America sets forth the following ethical judgments in the conviction that they are in continuity with biblical concern for the poor, and are obedient administration of its understanding of God's grace and the abundance of nature.

1. We rejoice in the applied achievements of science and technology which make it possible, currently in industrially developed countries and potentially throughout the whole world, to provide basically adequate levels of living for all.

2. We approve of declarations of public policy in our own countries (U.S.A. and Canada) which seek to eliminate the paradox of poverty in the midst of plenty and further seek to open to everyone opportunities for education and training, for work, and for living in decency and dignity.

3. We believe that in nations where conditions of abundance exist, it should be the goal of the national economy to provide every able-bodied adult with the opportunity for meaningful employment sufficiently remunerative to secure, at the very least, the minimal necessities required in our society for living in decency and dignity. Further, where a full employment economy is not possible or not desirable, or where individual inadequacies exist, we believe our countries have the responsibility to move as readily as possible to assure income adequate to secure the minimal standard of living.

4. We believe that although the establishment of social justice is primarily a responsibility of governing authority, it is appropriate that innovative programs designed to counteract the causes of economic deprivation be enacted by any agencies having such responsibility.

5. We recognize that, in a time of population explosion, the problems of hunger and poverty cannot be solved without substantial attention to population planning. We affirm the responsibility of governmental and nongovernmental agencies to make available to the deprived the same knowledge and means of conception control already available to others.

6. We are reminded by the "revolution of rising expectations" of the universal dimensions of the present challenge to eradicate poverty. Any commitment to the elimination of domestic poverty must be accompanied by a commitment to seek justice in the reduction of the disparity between rich and poor nations by programs designed to assist the developing nations to raise their standard of living.

7. We encourage the congregations, the synods and the agencies of the church to be open to the kind of cooperation with public and voluntary agencies which as a part of the church's witness to God's love in Jesus Christ will enable them to participate in the struggle against poverty in measure fully consistent with the resources God has given us and our responsibility for the use of those resources.

The Lutheran Church in America commits itself to the struggle against poverty in full continuity with the biblical testimony about concern for the poor. While it recognizes that the forms of this struggle are subject to human judgment and are open to differences of opinion among fully committed Christian persons, it does not believe that commitment to the struggle is an open question for Christians.

Mr. ULLMAN. Thank you very much.

Mr. CONABLE. Mr. Chairman?

Mr. ULLMAN. Yes, Mr. Conable.

Mr. CONABLE. Just a technical question.

Does the Lutheran Council in the United States of America represent all the synods of the Lutheran Church?

Dr. WHITING. The Lutheran Council in the United States of America is a council, sir, of these three Lutheran Church bodies, which are named in the introduction: The American Lutheran Church, the Lutheran Church in America, and the Lutheran Church-Missouri Synod. These Lutheran churches constitute about 95 percent of the Lutherans in this country.

Mr. CONABLE. Ninety-five percent.

Thank you.

Mr. ULLMAN. Dr. Whiting, just one question. You have given us a very thoughtful statement and one that needs to be digested very thoroughly. You do then concur that the basic welfare system should be taken over by the Federal Government as has been proposed by the administration and operated under the social security system?

Dr. WHITING. If by that, Mr. Chairman, you mean Federal assistance of a minimum level of income maintenance as outlined in the proposed family assistance plan, yes.

Mr. ULLMAN. Are there any questions?

Mr. Burke?

Mr. BURKE. I would like to direct your attention to the problem of child welfare in this Nation and would like to have your observations on it. This year the Federal Government is spending \$57 million toward this problem while there is an authorization of \$110 million. This means that the Federal Government is contributing from 6 to 9 percent toward the upkeep of these children in comparison to 50 to 83 percent for the children under AFDC. I was wondering if your organization favored the full expenditure of the \$110 million that is authorized and whether or not you would recommend that the Federal Government take a greater interest in these 700,000 children throughout the country who are actually wards of the State. They have no parents. They have no mother to take care of them or no father, and they are usually farmed out to some home. I know in Massachusetts they are spending in the child division of the welfare department close to \$20 million this year and the Federal Government is contributing about 6 percent toward this problem.

I was wondering if your organization had any thoughts on improving the conditions for these youngsters and whether or not you believe the Federal Government should take more interest in these most disadvantaged children?

Dr. WHITING. Well, Mr. Burke, I can only say, in response to these questions as to whether the Government should do this through public welfare, or other questions, it seems to me we must put these answers and these responses within the context of what we expect the total community to assume. There is no one single answer to the problem of a child. Certainly all the elements of the community, our schools, our libraries, our youth groups, certainly we in the church have a real responsibility to bear our share of the load for the protection and services to children in our society. But having said that, yes, I would say that certainly we believe that there is a very real need for the strengthening and extension of our governmental child welfare services.

I would believe, however, and this is my own personal judgment, that these services should be locally operated. I would not believe that the Federal Government as the Federal Government should operate child welfare services. Rather, these should be administered and conducted by local units of government, but certainly with massive financial support from the Federal Government.

Mr. BURKE. I agree with you that the Federal Government should not exercise the control. It is my opinion that these youngsters, having no parents, no one to speak up for them, seem to be in a vacuum and they lack the political muscle, they lack a voice. There seems to be an attitude throughout the Government that there is no reason to be concerned about the plight that they find themselves in.

I think it is a very unhealthy situation when you find 10 youngsters put into a rural home and the sum of money of about \$2 a week or \$3 a week given to their upkeep, and I often wonder what type of future citizens are we raising here with a complete ignoring of the plight that these youngsters are in.

At least in the AFDC case, with the mother in the home, there is some love and concern given to these youngsters, but in examining the records over the past 4 or 5 years I am shocked to find out that the Federal Government contributes so little towards the upkeep of these youngsters.

I was hoping that organizations such as your own and other groups would evince their interest, and I know of your great work, in the plight of these youngsters and try to prevail upon the Members of Congress and the administration to raise up the ante, so to speak, so that we can make a meaningful contribution, because the basis of most of these problems is the money that has to come forward to take care of these youngsters. It shocks me when I look into many of the States throughout the Nation where these youngsters happen to be abandoned in the hospital and are thrown upon the States. There is difficulty in getting them adopted and being put into homes and there is a very small amount of money contributed to them. I know you have a busy program and you are more than likely overwhelmed with your work, but I would hope that you could give some additional attention to this problem. I know that there are some people that would appreciate it.

Dr. WHITING. Thank you.

Mr. BURKE. Thank you.

Mr. CONABLE. Mr. Chairman?

Mr. BURKE. Mr. Conable.

Mr. CONABLE. What is the role of the church in welfare today? Have you become almost entirely social action groups?

I know you maintain some church institutions. Do you still have substantial welfare programs of your own related to the impoverished members of your own particular congregations? I know there is a great difference in churches, but I would be interested in your views as to whether or not the church still does have a direct function in the welfare system of this country.

I know we hear a lot of lip service given to pluralism generally but it seems to me that there is an increasing pressure on the Federal Government to accept the entire role for welfare. In the past, partly because our public institutions were not willing to accept this role, the churches have fulfilled a very substantial role themselves.

Dr. WHITING. Mr. Conable, I can only say from the point of view of our Lutheran understanding of the role of the church in social welfare, we firmly believe that this is a dual role. That is to say, we are concerned about direct services to people in trouble. Our Lutheran Churches in this country presently operate some 400 or more health and welfare agencies around the country. These include hospitals, child welfare agencies, both child placing as well as residential group care facilities for children, family service agencies, services to the aging, services to the handicapped, to the retarded.

Since you raise the question, I am not making the statement as one of pride, but it is a statement of fact that the Lutheran Church in this country does indeed believe most firmly that we have a responsibility to provide direct services to people who are in trouble in a wide variety of patterns.

We also believe equally that the church has a responsibility to make its contribution in this whole area of the development of social policy. We believe that this is certainly a part of our citizenship responsibility. Indeed, it is a part of our whole Christian responsibility to make a contribution in the development of social policy. In sum, to answer your question, sir, we believe the role of the church in social welfare is to provide meaningful, helpful services to people in trouble as well as to make its contribution in the development of a social policy.

Mr. CONABLE. Thank you, Mr. Chairman. That is all.

Mr. BURKE. On behalf of the committee, we wish to thank you for appearing here today. You made a great contribution, and we appreciate your testimony.

Dr. WHITING. Thank you.

Mr. BURKE. Our next witnesses are Alex Holstein and Hyman Bookbinder.

We welcome you to the committee, and you may introduce your associates and then proceed.

STATEMENTS OF ALEX HOLSTEIN, CHAIRMAN, SUBCOMMITTEE ON SOCIAL WELFARE, AMERICAN JEWISH COMMITTEE, AND HYMAN BOOKBINDER, WASHINGTON REPRESENTATIVE; ACCOMPANIED BY MRS. ANN WOLFE, PROFESSIONAL STAFF

Mr. BOOKBINDER. My name is Hyman Bookbinder. I am the Washington representative of the American Jewish Committee. And in just a moment I will introduce Mr. Alex Holstein, who is a distinguished

official of the agency and chairman of our special committee on social welfare. And we are accompanied by Mrs. Ann Wolfe, who is on our professional staff.

Mr. BURKE. Before you proceed, may I recognize you as an expert in the field of poverty because of your background and experience. We certainly are looking forward to your testimony and that of your associates.

Mr. BOOKBINDER. Thank you very much.

I didn't think you would recognize me behind my new beard, so I was going to say myself what I have done in the poverty field. But Mrs. Ann Wolfe is here, who is an official on our New York staff of the National Social Welfare Committee, and she will participate as our discussion warrants.

I have a very brief statement, but I will sum that up and be brief, because I know there is a time problem facing the committee.

As you were so kind to note, I have been associated with the Government's war on poverty. I served as the executive officer of President Johnson's Task Force on Poverty back in 1964, and then I served for several years as Assistant Director of OEO. And while I served with the OEO, I also served as a Special Assistant to advise Vice President Humphrey in the field of poverty and related matters.

During the last couple of years with the American Jewish Committee, my principal aim has been to try to identify those developments in social policy which could contribute toward the amelioration of poverty and, more important even, the amelioration of the great confrontations and conflicts we are having among groups in our society.

I think you would guess from this background that I was probably not the cheerleader for the man who now sits in the White House, but I am happy to say, and I feel it is a duty for me to say, that in my judgment after 6 years of experience with the poverty program and observing it in the last 2 years I believe that essentially Mr. Nixon's recommendations are very, very sound and should serve as the basis for the next important round in the development of social-welfare legislation in this country.

As Mr. Holstein's testimony will soon indicate, we have some serious problems with it, but I would like to stress as sincerely as I can that we ought not to let these problems detract from the important basic principle which is involved here, and that is that the Federal Government has a responsibility to improve this system, to play a larger role in it, and to undo the mistakes that in effect have developed over these last 20 or 30 years, not because we meant to do some things but because they turned out to be not exactly what we wanted.

I hope that we will not let happen in this case what happens so often where the best that people think of turns out to be the enemy of the good. We ought to enact a good welfare program, and I believe this Congress has an obligation to do so.

I must say very frankly—and I hope not with any discourtesy implied in it—that after several weeks of public attention to this important matter of the welfare changes I sense a great reduction in interest both in the Congress and outside the Congress in this particular field. I would hope that by our appearance here, by the appearance of other important public-interest groups, we revive this interest, because the country cannot stand indefinite postponement of basic changes that must be made.

I wanted to say a brief word about my experience in the poverty program. As you well know, the philosophy of the poverty program was not to ameliorate poverty. Our aim in the poverty program was not to make it somewhat more secure or less miserable while you are poor. We said that was somebody else's job. The war on poverty had as its objective getting people out of poverty permanently.

But I must say now, looking back over these 6 years, that the first enthusiasms that we had and the first expectations have turned out not to be exactly what we then felt. We found that getting people out of poverty at this time in our history, the kind of poverty we have, is simply even more hard-core than we realized at the time. And no matter how much we do and must continue to do, in fact, to get people out of poverty and into the economic mainstream, I now realize, many of us now realize, we will, in fact, for an indefinite number of years have a significant number of Americans who must be dependent upon some form of income maintenance.

And so some of us have increasingly turned out attention to what do we do about making our system more humane, more positive, more constructive, a greater contribution, in fact, to move people from welfare to economic self-support.

I think that we can make significant progress in the context of the President's recommendations. And in order to discuss just what we like about it and what we do not like about it, I am very happy that we can turn now for the statement on the program as such, to Mr. Alex Holstein, unless you would like to ask me any questions now.

But I think perhaps we can have the whole presentation and then be available to you.

(The statement referred to follows:)

STATEMENT OF HYMAN BOOKBINDER, WASHINGTON REPRESENTATIVE OF THE
AMERICAN JEWISH COMMITTEE

For the past 2 years, as Washington Representative of the American Jewish Committee, I have been concerned primarily with identifying and calling to the attention of my agency those developments in public policy which could contribute to the easing of the polarizations and the antagonisms that are threatening the very fabric of our democratic society. For four years before that I was associated with the Federal government's war on poverty, first as Executive Officer of President Johnson's Task Force on Poverty and then as Assistant Director of the Office of Economic Opportunity. Between 1965 and 1967 I served also as Special Assistant to Vice President Hubert Humphrey in the area of poverty and urban affairs.

It is my sincere belief that, except for the initial commitment itself in 1964 to wipe out poverty in this fabulously rich nation, President Nixon's proposals to reshape the nation's welfare system constitute the most exciting and promising challenge of the last six years. It would be a great tragedy if the combination of those who think the program goes too far and those who think it does not go far enough should succeed in keeping this program from being launched. As we shall soon indicate in our testimony, the proposals do fall short in some important respects—but I wish to state unequivocally at the outset that the Administration's basic proposals are clearly in the right direction and should receive the earliest possible approval by this Committee and by the Congress. We must not, as happens so often, permit the "best" to be the enemy of the "good." But of course we should try to make the final legislation as good as possible.

The anti-poverty program, as it was conceived in 1964 and as it has been administered ever since, is concerned not with the alleviation of poverty as such, but with helping people to escape from it. While some of its programs did add to the income of the poor, such as the Neighborhood Youth Corps, its essential purpose was not income maintenance but that of developing greater

capability to enter the economic mainstream of society. But if any of us entertained visions of quick success in moving all poor people from dependency to self-support, we soon gave up that vision. We learned that hard-core poverty in the America of the Sixties is even more hard-core than we had thought, that for many of the poor the road out of poverty would be long and hard. The best we could hope for in the case of many Head Start children, for example, was that they would not be the parents of yet-to-be-born poor children fifteen or twenty years from now. And there were the millions of aged and handicapped who never could become self-sufficient.

And so, while we all learned to make great speeches about getting people "off the welfare rolls and onto the payrolls"—which we believed then and still believe today is a worthy and urgent objective of social policy—we also learned that millions of Americans would just have to remain on welfare rolls for years to come. How to make the welfare system more humane, more generous, more constructive, increasingly became our concern.

That is why the proposals put forth by President Nixon strike me as being so essentially right and so timely. My associates will give you a summary of our analysis of the proposals. Basically, we believe that the assumption by the Federal government of the central responsibility in the nation's welfare system is long overdue.

I believe that an overhaul of the welfare system basically along the lines of the President's proposals is crucial. But I believe too that no improvements in our welfare system (or any other kind of income maintenance system) constitute the full answer to our poverty problem. There must be continued and improved programs in education, manpower training, housing, health, and the full range of rehabilitative and opportunity programs that we have started in the last ten years. These programs must always be under critical scrutiny, and they must be discarded or changed as warranted, but we must be prepared to wage a massive and continued attack on all causes and effects of poverty if we are to see its elimination before a whole new generation of poverty is upon us. There is no simple, single explanation for poverty in the United States today, and there is no single, simple program to end it.

The American Jewish Committee is a human relations agency—concerned with improved conditions not only for Jews but for all Americans. Recognizing that improved intergroup relations is so tied in with the elimination of poverty and dependency, we have added social welfare policies to our agency's agenda. And to present our analysis of the welfare proposals, we are joined by the Chairman of our Subcommittee on Social Welfare, Mr. Alex Holstein, Jr., and by Mrs. Ann Wolf, Program Consultant.

Before calling on Mr. Holstein, may I ask that there be included in the record of these hearings the text of the statement on this issue adopted on October 25, 1969, by the Executive Board of the American Jewish Committee.

STATEMENT OF ALEX HOLSTEIN, CHAIRMAN, SUBCOMMITTEE ON SOCIAL WELFARE, AMERICAN JEWISH COMMITTEE

MR. HOLSTEIN. Mr. Chairman, my name is Alex E. Holstein, Jr., of Syracuse, N.Y., and I am chairman of the National Social Welfare Committee of the American Jewish Committee, which I represent here today.

The American Jewish Committee is a national organization with chapters and units in 100 cities, and a membership of 40,000 persons. The American Jewish Committee was organized in 1906, and is incorporated by a special act of the Legislature of the State of New York in 1911.

Since its founding, the American Jewish Committee has been concerned with the strengthening of the democratic process, and with equality for all Americans, regardless of race, religion, or national origin. We believe that the existence of poverty in an affluent society breeds hostility and community tension and alienates one group from another.

There is compelling evidence of the intimate relationship between poverty, the inadequacy of welfare programs, and disorders. Indeed, the National Advisory Commission on Civil Disorders in its survey of 24 disorders in 23 cities identified inadequate welfare programs as one of the 12 deeply held grievances of the people.

The statistics paint a bleak picture: there are 30 million persons with incomes below the poverty level as defined by the Social Security Administration. About 9 million are receiving some kind of welfare assistance, the largest number under the AFDC and AFDC-UP programs. Even considering the wide disparity of grants from one State to another—\$9.30 a month per AFDC recipient in Mississippi and \$62.55 in New York, or a national average of \$36 monthly per recipient—we are led to agree with the National Advisory Committee on Public Welfare in the following statement:

The national average provides little more than half the amounts admittedly required by a family for subsistence; in some low-income states, it is less than a quarter of that amount. The low public assistance payments contribute to the perpetuation of poverty and deprivation that extend into future generations.

We believe that the inadequacies in welfare grants are a major source of social ills such as crime, juvenile delinquency, mental illness, and the climate of unrest, alienation, and discouragement among many groups and individuals in our population. In order to attack these problems effectively, we are convinced that the welfare system must be overhauled so that it will be more responsive to the needs of the people it serves.

Our national executive board meeting in Detroit on October 26, 1969, reviewed the bill incorporating President Nixon's proposals for revising the welfare system. My statement today reflects the position of the National Executive Board of the American Jewish Committee.

For many years, we have been concerned with the situation of poor people. We believe that the best bulwark against poverty is a prosperous nation that provides work opportunity for all, and adequate financial aid to those who cannot work. In the long run, we believe that America will need in the foreseeable future to consider a program of social insurance that will incorporate financial safeguards, health insurance for all, and a social security program that will ultimately make the existence of a public welfare system unnecessary. Until such time, the present welfare system must be revised.

Our national executive board commends President Nixon for his statement on revamping the welfare system. We believe that he has pointed up the serious problems that have resulted from our patch-work welfare and welfare-related programs, and that he has challenged the Nation to make fundamental changes. We applaud the fact that the President has initiated a much needed national discussion on how we must go about making our welfare system more humane, more effective, and more constructive.

Our analysis of the bill leads us to endorse three basic concepts incorporated in its proposals:

1. We favor the assumption of Federal responsibility for a welfare program which sets national benefits and eligibility standards.
2. We favor the inclusion of the working poor previously excluded from welfare provisions, and support supplementary assistance to such poor people.

3. We endorse the concept of a uniform minimum level of benefits.

Our analysis leads us to take exception to some of the proposals:

1. The suggested level of benefits is clearly too low, no matter by which standard it is gaged. Only by a substantial upgrading of benefit payments can those persons not in the labor force be assured a fair share of the national prosperity. Also, we believe that supplementary welfare payments to the working poor must be large enough to maintain the incentive for continued employment.

2. We take exception to some of the work incentive proposals, which, in our judgment, are coercive or discriminatory. We favor providing opportunity for training and employment, but the requirement for such work under the threat of withholding welfare benefits if the recipient refuses to register may prove to be unnecessary. All available data indicate that the number of people receiving welfare benefits who are employable is so low as to be negligible, when viewed from a nationwide perspective. To be sure, there may be a few who can work but do not, but this in our judgment is hardly the reason to incorporate provisions which perpetuate the mistaken notion that people on welfare are lazy, or that there is more dishonesty among this group of citizens than among any others. These are myths that should be dispelled.

3. The provision that requires mothers of school age children to register for training or work is also unnecessary. Given the opportunity for dignified work, coupled with good child care provisions, large numbers of mothers would choose to work. Where this has been provided, mothers have flocked to register to work. It should be pointed out that 50 percent of white mothers of children are in the labor force. Sixty percent of Negro mothers of children are working.

The President's proposals make no provision for day care for school age children. By requiring mothers of children over the age of 6 to work, we are in danger of producing a huge "latchkey" generation of children who wander the streets after school hours without supervision and without care. Under such circumstances, the dangers to children's health and safety, as well as the possibility of pernicious influences, are great. There are many mothers who might choose to work, but in our judgment this choice should be left to the mothers. We believe that poor mothers should have the same freedom of choice as do mothers of the middle and upper classes.

4. We are concerned that individuals and childless couples are omitted from the provisions of the President's proposals. Many people without children do not qualify for categorical assistance under the Social Security Act. We therefore urge that this committee consider the inclusion of single people and childless couples in the provisions of this bill.

5. The work incentive plan incorporated in the President's bill also raises some questions about the possible misuse of the worker, which we hope your committee will consider. The bill does not define reasonable employment, and there is the possibility that poor people may become a permanent group of exploited and underpaid workers. We would therefore hope that this committee would include a provision that no job in connection with eligibility for assistance be offered unless that job pays the Federal minimum wage or the prevailing wage for the industry, whichever is higher.

In conclusion, we should like to reaffirm our belief that America's poor need adequate housing, improved educational opportunities for their children, well run day care and preschool programs, better hospitals and health facilities, and a wide range of social services that will aid them to move out of the immobilizing atmosphere of poverty. We see the revamped welfare system as a step in the direction of providing adequate safeguards against poverty.

Our statement passed at our executive board meeting, makes the following clear:

As America goes about reordering its national priorities, major emphasis must be given—and major commitments must be made—to meeting the needs of the poor in our country * * *. We dare not repeat the mistakes of recent years in pronouncing large promises and performing meagerly. Much of the anger and alienation and disorders of recent years can be attributed to the gap that has developed between promise and performance.

We hope that there will be speedy passage of this significant domestic legislation proposed by the President, with the changes which we have suggested.

We believe, too, that we must in the near future begin to turn our attention to a broad, all-encompassing social insurance program that will insure the permanent well-being and security for all the American people.

We thank you for the opportunity that has been afforded us to make our views known to your committee.

Mr. BURKE. Thank you.

Mr. BOOKBINDER. May we have submitted for the record, too, the text of the resolution adopted by our executive board? It is attached to the statement that was handed you.

Mr. BURKE. Without objection, that will be included in the record. (The document referred to follows:)

STATEMENT ON PROPOSED WELFARE REFORMS ADOPTED BY THE EXECUTIVE BOARD
OF THE AMERICAN JEWISH COMMITTEE, OCTOBER 25, 1969

The American Jewish Committee commends the President for his statement on revamping the welfare system. His statement points up serious problems that have resulted from our patchwork welfare and welfare-related programs, and it challenges the nation to make fundamental changes. In making these proposals, the President has initiated a much needed national discussion, in the Congress and out, on how we must go about making our welfare system more humane, more effective and more constructive.

Poverty and dependency are always unsatisfactory, but are particularly dangerous in the midst of affluence. America can and must take the necessary steps to eliminate social and economic insecurity. America's poor come from all groups: a majority of whites and a disproportionate number of blacks; Jews and gentiles, old and young.

Our analysis of the basic proposals leads us to endorse three crucial breakthroughs which the President's proposals highlight:

1. The assumption of federal responsibility for a national system of welfare benefits and eligibility standards.
2. Establishing a uniform minimum level for benefits.
3. Inclusion of millions of working poor previously excluded from welfare provisions.

These three breakthroughs offer the promise of an important step in providing adequate income maintenance for every American family and for strengthening family life. However, the provisions of the President's proposals as incorporated in the bill submitted to Congress on October 2, 1969 include some questionable parts which in our judgment should be changed. These changes should include:

1. Increasing the proposed \$1600 minimum for a family of four (the official "poverty" level is \$3350).

2. Childless couples and individuals should be included in the program.

3. Flexibility should be maintained in applying work incentive proposals to mothers of children over six. The age of children, the numbers of children, the after-school care facilities available should be considered before mothers of school age children are compelled to take training or employment in order to be eligible for welfare payments.

Helping to place as many welfare recipients as possible in jobs is an appropriate and important goal, but this policy should be pursued sensitively and with realism. Only a relatively small number of present recipients are employable. They should be aided through every incentive and opportunity to become productive and self-reliant members of the community, either through private jobs or in public employment. We applaud the effort to aid those not presently employable to receive relevant training and job counselling. However, we urge that in this effort the federal government establish standards which cannot be violated by regions or states and which will not lend themselves to punitive measures or harassment. The proposed joint federal-state administration of this program highlights this danger.

The changes incorporated in the bill are an important step forward. But America's 30 million poor need more than this: they need adequate housing, improved educational opportunities for their children, well-run day care and pre-school programs, better hospitals and health facilities, and a wide range of social services that will aid them move out of the immobilizing atmosphere of poverty. All these will help to improve not only their material standards, but will raise the quality of life for the very poor. This will have an effect, too, on the total community, and may well result in more harmonious relationships between groups in the community.

As America goes about reordering its national priorities, major emphasis must be given—and major commitments must be made—to meeting the needs of the poor in our country. The President's welfare proposals have stirred new hopes and expectations both among America's poor and among Americans concerned with the elimination of poverty. We dare not repeat the mistakes of recent years in pronouncing large promises and performing meagerly. Much of the anger and alienation and disorders of recent years can be attributed to the gap that has developed between promise and performance.

We hope, therefore, that President Nixon will take vigorous action to insure the passage of this significant domestic program that he has set for America and that Congress will provide bipartisan support to secure speedy passage of this legislation. The President has recognized that this is the time for change in our welfare policies. There must be no delay and there must be no compromise. The change will be costly, but failure to change will be even more costly.

In this important endeavor the American Jewish Committee pledges its support.

Mrs. WOLFE. I don't have a special statement.

Mr. BURKE. Are there any questions?

Mr. Betts.

Mr. BETTS. I have just a couple of comments.

I think that you are right, Mr. Holstein, to think that maybe we have slackened in our interest in this subject, but I think it is answered this way: that we have to shift our attention occasionally from one subject to another, as part of the job, and I don't think that overall anybody has lost any interest in this subject.

I just want to assure you of that.

Mr. HOLSTEIN. I am glad to hear it.

Mr. BOOKBINDER. Perhaps I did not make myself clear. I did not mean the Ways and Means Committee. As a matter of fact, we were surprised and delighted that the committee started hearings on this bill so very, very quickly.

I did not mean anything of that nature.

Mr. BETTS. I was going to defend you, because I think you had a right to suspect that there might be some slackening of interest.

Mr. BURKE. Will the gentleman yield at that point?

Mr. BETTS. Yes.

Mr. BURKE. I might just point out, to make an observation here, that when these hearings started, these two press tables were loaded with newspaper men, but, once the administration completed their side of the story, the press then started to disappear, and if you notice right now there is no one sitting at either press table.

Mr. BOOKBINDER. We are going to help get that word out around the country.

Mr. BURKE. That is why your organizations are so important.

Mr. CONABLE. Will the gentleman yield further?

Mr. BETTS. Yes.

Mr. CONABLE. I think we have a very serious practical problem facing us in this committee, too, as to whether or not we should divide the different subjects of the social security omnibus bills, and consider welfare separately from social security.

I wonder if you have any views on that. It has something to do with the public interest in the bill, and something to do also with the political acceptability of the package, which, as you know, we are likely to present to the House as a whole under the type of closed rule which has become traditional with this committee.

Mrs. WOLFE. I think, sir, that listening to testimony on both subjects is very important at this time, because ultimately, without being a sage or a prognosticator, I think social security in this country will end up being the program that includes all kinds of provisions for poor people.

However, we have never had a program as broadly defined as President Nixon's proposals, and it seems to me that more attention at this time must be given to an understanding of what is involved in these proposals, and the great possibilities open to the country, if these proposals, with some amendments, are adopted.

So, I would think that having public hearings on that alone for a period of time would help prepare the country to understand what is involved.

Now, I understand the political need to get this program accepted by the people, and social security is one of our great programs and may well enhance the acceptability of the other.

Mr. CONABLE. Originally, welfare was included in the Social Security Act, not because it bore any direct relation, but because in the opinion of President Roosevelt the two might enhance mutually the opportunities for congressional acceptance.

Mr. VANIK. Will the gentleman yield, Mr. Chairman?

Mr. BETTS. Yes.

Mr. VANIK. I would like to point out that the question was directed toward what your reaction would be toward the separation of the issues.

The more we get into the welfare program, the more we see that we have to do a pretty extensive job that is going to require care and considerable work by this committee and by the Congress.

Now, the issue is: Should we hold off granting some kind of across-the-board increase to the needy aged and the elderly citizens of America while we work out this welfare program?

I think this welfare program can be made good enough and strong enough so that it can be acceptable to the American people without

having to resort to the procedure of making it a part of a combined package.

I think it would be dreadful if we were to hold back and deny the elderly of America the increase which they need in order to exist under the present inflationary spiral. It would be dreadful to hold them back while we deliberate and ponder and work out this extensive welfare program.

Don't you agree on that?

MR. BOOKBINDER. Mr. Vanik, I would not presume to suggest to the Ways and Means Committee how it should deal with this bill in a technical sense.

I know that you are by far the most overworked committee in the Congress.

I do not want any retired person deprived of a single payment of an increased amount, if this would hold it up, but I do want to articulate a fear that I have, and I want to stress this fear; that as long as the welfare consideration is part of the social security one, there will continue to be at least some interest in it.

I would hope that if the committee makes the judgment, which it alone must make, that in order to get expeditious handling of the social security increase, it must separate it, that it does not then put this next thing on the shelf for an indefinite postponement, but that it remain the continuing business of this committee, because this one cannot wait, either.

MR. VANIK. That is right. I agree with you. But you do understand the complexities that are involved.

MR. BOOKBINDER. I do.

MR. VANIK. For example, if the gentleman will yield further, just the other day I was trying to figure out the number of people affected by the welfare proposals.

When you separate from the proposals all of those people that are veterans of World War II, all of their families—for they have their own program—the number affected is greatly reduced.

So that if you take those people out, those people who can qualify under the veterans' program if we exclude that great number of people, and other groups that are excluded under the provisions of the President's recommendation, when you boil it down, it does not really affect very many new people.

I concur in what you say, to expand the eligibles and to also make the minimum payment a lot more realistically in line with the bare bones cost of existence.

MR. BOOKBINDER. And then it will involve very many more people, that way.

MR. VANIK. That is right.

MR. CONABLE. If the gentleman will yield, even as it is, it affects apparently an additional 12 million people, under the working poor provisions. That is not a small number.

MR. VANIK. When we get into executive session, I would like to get into that issue, because I don't believe that it reaches that many people, when you exclude the various groups.

That is a matter of opinion.

MR. CONABLE. Opinion to the contrary notwithstanding, all we have at the present time is the estimate by the executive branch that it would affect that many people.

Mr. BURKE. Are there any further questions?

Mr. FULTON. Mr. Chairman.

Mr. BURKE. Mr. Fulton.

Mr. FULTON. I would just like to compliment the three witnesses before the committee now, and to say that I find myself almost in 100 percent agreement with everything that you have suggested to this committee.

Mr. BOOKBINDER. Thank you very much.

Mr. CONABLE. Mr. Chairman.

I would like to apologize for involving you in our technical problems.

Mr. BOOKBINDER. No. As a matter of fact, if I may just take a few minutes, I have been in this town for 20 years, and with all respect, the question you raised has been raised over and over again, and I expect will not be solved before the welfare bill is modified.

Mr. BURKE. We wish to thank the three witnesses for their contribution here today.

Mr. BOOKBINDER. Thank you.

Mr. BURKE. Our next witnesses represent the International Association of Fire Fighters.

Will you please identify yourself for the record, and then you may proceed.

STATEMENT OF JACK A. WALLER, LEGISLATIVE REPRESENTATIVE, INTERNATIONAL ASSOCIATION OF FIRE FIGHTERS; ACCOMPANIED BY LEONARD B. KERSHNER

Mr. WALLER. Mr. Chairman and members of the committee, I am Jack Waller, the legislative representative of the International Association of Fire Fighters.

President McClellan of our organization sends his regrets at not being able to be here this morning. He was taken ill during the night and did not feel up to making his testimony today.

Mr. BURKE. I am sorry that Howie McClellan is not here. I have known him for many, many years.

Mr. WALLER. We know that, Mr. Burke.

Mr. BURKE. I know of his great work on behalf of the firefighters.

If you will extend my personal regrets and also my wishes for his early recovery, I will be grateful.

Mr. WALLER. I certainly will, and thank you very much.

I have with me this morning Leonard Kershner. Leonard is the secretary-treasurer of the Associated Fire Fighters of Connecticut, and also executive vice president of the Connecticut State AFL-CIO.

Leonard for many years has been a student of the problem of social security and the firefighter, and with your indulgence will make our testimony this morning.

STATEMENT OF LEONARD B. KERSHNER

Mr. KERSHNER. Mr. Chairman, my name is Leonard Kershner, and I appear here today in behalf of our international union, which consists of approximately 150,000, and is the exclusive representative of the overwhelming majority of professional firefighters in the United States and Canada.

We appear here today, Mr. Chairman, to voice our wholehearted support for S. 2969, introduced by U.S. Senator Abraham Ribicoff, of Connecticut.

The purpose of this bill, Mr. Chairman, is to permit any State to make an agreement with the Secretary of Health, Education, and Welfare to purchase hospital insurance protection for employees of the State or its political subdivisions who are not now covered by the Social Security Act or the Railroad Retirement Act.

Our organization has consistently opposed efforts to bring firefighters under social security, because we are convinced that State and local retirement systems which provide for retirement at an earlier age than that allowed under social security are far better suited to meet the needs of our members and the communities they serve.

As the chairman knows, the work of firefighters demands great physical strength, agility, coordination, stamina, and endurance. Most men begin to lose a good part of these characteristics after they reach age 50, thus reducing their effectiveness on the job.

For this reason, Mr. Chairman, early retirement for such workers is necessary in order to maintain efficiency in the firefighting service.

It is quite clear to us, Mr. Chairman, that retirement insurance protection for firefighters can best be handled at the State or local level, where such protection is tailored to cope with the special problems arising out of the extraordinary nature of the firefighters' work.

That Congress apparently agrees with us on this point is evidenced by the fact that the law specifically excludes firefighters from social security coverage.

Therefore, Mr. Chairman, since firefighters are excluded from social security for good and valid reasons, this exclusion should not be used to deprive them of the protection of the federally administered health insurance program.

But unfortunately, and in our judgment unfairly, the law, as it now stands, does deny firefighters the benefits of the hospital insurance provisions of title XVIII, solely because they are excluded from social security retirement coverage.

Senator Ribicoff's bill would correct this gross inequity by permitting any State to enter into an agreement to also cover under said hospital insurance provisions those firefighters who are not covered under social security.

Although firefighters and certain other State and municipal employees have special needs in the area of retirement insurance protection, their needs and those of all people are universal when it comes to health insurance protection.

Congress has already recognized the universality of the Nation's health insurance needs by making the supplementary medical insurance provisions of title XVIII available to everyone 65 years of age or older, without regard to entitlement to retirement benefits under social security or the Railroad Retirement Act.

The logical extension of this concept requires that the hospital insurance provisions of this same title XVIII should also be made available to everyone 65 years of age or older, without regard to Railroad Retirement or social security entitlement.

Presently, firefighters and certain other State and municipal employees are being discriminated against in the field of health insur-

ance protection solely because their retirement needs are different from those of most workers.

S. 2969 will end that discrimination by permitting States to extend to firefighters and such other State and municipal employees the same health insurance protection enjoyed by the general work force.

Mr. Chairman, the International Association of Fire Fighters believes that the Ribicoff bill represents the minimum of justice to which our members are entitled, and we respectfully urge this committee to give it favorable consideration.

Mr. Chairman, we also have a very brief statement on House Resolution 292 and House Resolution 9829, dealing with a somewhat different subject matter.

Mr. BURKE. Would you like to have those included?

Mr. KERSHNER. We would like to have those included in the record.

I wondered if the committee at this point would want to interrupt for any questions on the Senate bill 2969.

Mr. BURKE. Without objection, we will include this statement on H.R. 292 and H.R. 9829, bearing the signature of William H. McClellan, the president of the International Association of Fire Fighters, AFL-CIO.

(The prepared statement of Mr. McClellan and the documents referred to follow:)

STATEMENT OF WILLIAM H. MCCLELLAN, INTERNATIONAL ASSOCIATION OF FIRE FIGHTERS, AFL-CIO-CLC

Mr. Chairman, members of the committee, my name is William H. McClellan, I am president of the International Association of Fire Fighters, AFL-CIO. With me today is Jack A. Waller, our legislative representative, and Leonard B. Kershner, secretary-treasurer of the Uniformed Fire Fighters of Connecticut.

Our union, consisting of 150,000 members, is the exclusive representative of the overwhelming majority of professional firefighters in the United States and Canada.

We appear here today to voice our wholehearted support for S. 2969, introduced by U.S. Senator Abraham Ribicoff of Connecticut.

The purpose of this bill is to permit any State to make an agreement with the Secretary of Health, Education, and Welfare to purchase hospital insurance protection for employees of the State or its political subdivisions who are not covered by the Social Security Act or the Railroad Retirement Act.

Our organization has consistently opposed efforts to bring firefighters under social security because we are convinced that State and local retirement systems which provide for retirement at an earlier age than that allowed under social security are far better suited to meet the needs of our members and the communities they serve.

The work of firefighters demands great physical strength, agility, coordination, stamina and endurance. Most men begin to lose a good part of these characteristics after they reach age 50, thus reducing their effectiveness on the job. Early retirement for such workers is necessary in order to maintain efficiency in the fire-fighting service.

It is quite clear that retirement insurance protection for firefighters can best be handled at the State or local level where such protection is tailored to cope with the special problems arising out of the extraordinary nature of the firefighters' work.

That Congress apparently agrees with us on this point is evidenced by the fact that the law specifically excludes firefighters from social security coverage.

Therefore, since firefighters are excluded from social security for good and valid reasons, this exclusion should not be used to deprive them of the protection of the federally administered health insurance program.

But unfortunately, and unfairly, the law, as it now stands, does deny firefighters the benefits of the hospital insurance provisions of title XVIII, solely because they are excluded from social security retirement coverage.

Senator Ribicoff's bill would correct this gross inequity by permitting any State to enter into an agreement to also cover under said hospital insurance provisions those firefighters who are not covered under social security.

Although firefighters and certain other State and municipal employees have special needs in the area of retirement insurance protection, their needs and those of all people are universal when it comes to health insurance protection.

Congress has already recognized the universality of the nation's health insurance needs by making the supplementary Medical Insurance provisions of Title XVIII available to everyone 65 years of age or older, without regard to entitlement to retirement benefits under Social Security or the Railroad Retirement Act.

The logical extension of this concept requires that the Hospital Insurance provisions of this same Title XVIII should also be made available to everyone 65 years of age or older, without regard to Railroad Retirement or Social Security entitlement.

Presently, Fire Fighters and certain other state and municipal employees are being discriminated against in the field of health insurance protection because their retirement needs are different from those of most workers.

S. 2969 will end that discrimination by permitting states to extend to Fire Fighters and such other state and municipal employees the same health insurance protection enjoyed by the general work force.

The International Association of Fire Fighters believes that the Ribicoff bill represents the minimum of justice to which our members are entitled, and we respectfully urge this Committee to give it favorable consideration.

Re: H.R. 292—Introduced by Representative Robert H. Michel; H.R. 9829—Introduced by Representative Harold R. Collier.

The International Association of Fire Fighters would also like to take this opportunity to urge that the Committee act favorably on H.R. 292, or H.R. 9829. These are identical bills which would permit Policemen and Fire Fighters who had been covered under Social Security as individuals and who were subsequently covered by a state or local retirement system, in which membership was mandatory by law, to elect to terminate his Social Security coverage.

As we have previously noted, Fire Fighters are excluded from coverage under Social Security. Policemen are also covered by the same exclusion clause. However, this exclusion does not apply to Fire Fighters and Policemen who do not have a retirement system.

Instead, such Fire Fighters and Policemen who do not have a retirement system may, through an agreement between the state and the Secretary, be covered under Social Security as individuals.

A certain number of Fire Fighters and Policemen have been covered under Social Security as individuals at a time when they did not have a retirement system. Some time thereafter a state or a local retirement system was established for such Fire Fighters which more adequately met their needs. Participation in such state or local retirement system is frequently mandatory. As a result, such Fire Fighters and Policemen are required to participate in both Social Security and the state or local retirement system and pay taxes or contributions to both. The cost of this double tax or double contribution is quite often prohibitive and an excessive burden on the Fire Fighter.

H.R. 292 and H.R. 9829 will permit such Fire Fighters and Policemen to elect, through procedures prescribed by regulations to terminate their Social Security coverage and to thereby eliminate this burdensome duplicate tax.

It should be noted that sub-paragraph (C) provides that these bills will not apply to those Policemen and Fire Fighters in those 19 states which have been exempted from the exclusion clause.

This provision would dilute the effectiveness of these bills, and we respectfully recommend that sub-paragraph (C) be deleted.

Adoption of these bills can in no way injure the Social Security Fund. To the contrary, the Fund will benefit to the extent that contributions to the Fund have been made by such employees and in behalf of such employees; yet if they elect to terminate their Social Security coverage, no benefits will be paid out in return for such contributions.

These are good bills and we again request that the Committee act favorably thereon, noting the Union's recommendation that sub-paragraph (C) be deleted.

Mr. BURKE. Mr. Betts.

Mr. BETTS. I think Mr. Vanik will agree with me that he and I have always had a problem with social security for firemen and policemen in Ohio. They have historically rejected the idea.

Is there anything about your proposal which would conflict with the position that the police and firemen have taken in Ohio?

Mr. KERSHNER. Not at all.

We believe our position with respect to social security is entirely consistent with the position taken by the policemen and firefighters in the State of Ohio, and throughout most of the country, and I am certain that this is consistent with the position taken by the firefighters in Ohio.

I don't presume to speak for the policemen, but I suspect the position of the policemen is also the same as that of the firefighters in Ohio.

Our position, very simply, Mr. Betts, is that in the area of retirement benefits, those needs of the firefighter can best be met at the State or the local level. My understanding is that in Ohio it is handled at the State level, and there is a State law covering retirement benefits for firefighters.

However, when we get to the area of health insurance protection, our needs are universal. We think that the firefighter in Ohio has the same need for health insurance protection that the steelworker has in Indiana, or the carpenter in California.

We think in the area of health insurance protection our needs are universal, and that this can be best met through the federally administered health insurance program that now is related to social security solely for convenience in terms of raising the funds necessary to finance the program.

We think that Senator Ribicoff's bill has admirably solved that problem of raising the necessary funds to finance the program as it applies to those State and municipal employees who for good and valid reasons are not covered by the social security retirement provisions.

Mr. BETTS. In other words, there is no problem in a State where the policemen and firemen are already covered by social security. Is that correct? They automatically are covered?

Mr. KERSHNER. This law solely applies—

Mr. BETTS. I mean forget this bill. The question of health insurance for policemen and firemen who are on social security poses no problem in States where they are allowed to participate now, does it?

Mr. KERSHNER. No.

Mr. BETTS. It would be a problem only in a State like Ohio, where they don't participate and make contributions?

Mr. KERSHNER. Ohio, Connecticut, Massachusetts.

Mr. BETTS. Just to reask you to repeat what you said, what is the Ribicoff method of financing the program?

Mr. VANIK. How does the Ribicoff bill provide the local contribution?

Mr. KERSHNER. The Ribicoff bill would permit any State to enter into an agreement with the Secretary of HEW to purchase on the basis of actual costs to the people covered the benefits provided for under those hospital insurance provisions of title XVIII.

Mr. VANIK. The premium would be paid by the State or the local agency?

Mr. KERSHNER. The statute would require the payments to be made by the State. However, the State could certainly be free under this provision to enact legislation which would divide the cost of this program among employees and the municipalities covered by the agreements.

Mr. VANIK. Would you not appreciate it, Mr. Betts, if this organization could provide for us the exact impact in our State on this issue, so that we could relate it?

Mr. BETTS. Yes, and I presume the firemen in Ohio are members of your organization. Is that correct? Their organization is a member of your national organization?

Mr. KERSHNER. Yes. The overwhelming majority of firefighters in the State of Ohio are members of our organization.

Mr. BETTS. They are aware of your presentation here this morning?

Mr. KERSHNER. Yes, they are.

Mr. VANIK. And this is principally a problem in those States where there is a separate retirement fund, in which a certain select group of employees prefer the benefits of that fund rather than the old age benefits of social security?

Mr. KERSHNER. Precisely. That is exactly the point to which the Ribicoff bill is directed.

Mr. BURKE. Are there any further questions?

The committee wishes to thank you for your testimony, and we would appreciate it, too, if you could send us personally, not for the record, any information with regard to how it affects the firefighters in our local States, particularly Massachusetts, Ohio is a little bigger than we are.

Mr. KERSHNER. Mr. Chairman, the application in Massachusetts would be identical to the application in Ohio. The policemen and firefighters in both Massachusetts and Ohio are not covered by the retirement provisions of the Social Security Act. They instead have protection of their local plans.

Mr. BURKE. Off the record.

(Discussion off the record.)

Mr. BURKE. Thank you.

Mr. KERSHNER. Thank you, Mr. Chairman.

Mr. BURKE. Our next witness is John P. Meehan.

On behalf of the committee, I wish to welcome you, Mr. Meehan. I have known you for many years, and I recognize that you are an authority on this subject, and also on H.R. 5.

**STATEMENT OF JOHN P. MEEHAN, SECRETARY, AND CHAIRMAN
OF COMMITTEE ON FEDERAL LAW AND LEGISLATION, NATIONAL
ASSOCIATION OF LIFE UNDERWRITERS; ACCOMPANIED BY
WELTON J. FISCHER, TAX COUNSEL; AND MICHAEL L. KERLEY,
COUNSEL**

Mr. MEEHAN. Thank you very much, Mr. Chairman.

For the record, my name is John P. Meehan, CLU, of Boston, Mass., and I am appearing before your committee today as the chairman of the Committee on Federal Law and Legislation of the National Association of Life Underwriters, and also as secretary of the association's board of trustees.

I am accompanied by two of our Washington staff attorneys, Mr. Welton Fischer and Mr. Kerley.

This has been a very heavy workload this year for this committee and we appreciate the heavy job this committee has taken on, and Congress.

For your information, our organization is a trade association composed of over 950 State and local life underwriter associations, representing a membership in excess of 100,000 life insurance agents, general agents, and managers residing and doing business in virtually every locality of the United States.

We appreciate this opportunity to present our views with respect to certain of the proposed revisions in the social security system.

Prior to making specific comments on the recommendations for amendments contained in H.R. 14080, I should like to summarize our basic position with regard to the social security program and its objectives and purposes.

NALU'S BASIC PHILOSOPHY REGARDING SOCIAL SECURITY

We believe that the social security program was designed to provide a basic floor of protection against economic want and need, financed by earmarked taxes imposed upon employers, employees, and self-employed individuals, and by earnings on the Social Security trust funds. It was intended that upon this basic floor, each covered person, by individual and employer initiative, would plan and build additional economic security for himself and his family by means of private savings, investments, insurance, pension programs, and the like.

As thus originally conceived and designed, the social security program is socially and economically desirable. But to insure its continued existence, it is essential that the program be soundly maintained. Overexpansion of the program must be avoided, since such overexpansion would substantially increase the tremendous financial burden already facing present and future social security taxpayers, and pose a threat to the safety and continued existence of the program itself.

NALU CONCLUSION REGARDING MAJOR FEATURES OF H.R. 14080

NALU believes that the major features of H.R. 14080 are in keeping with the basic floor of protection concept. Therefore, NALU endorses and supports the provisions of the bill which would increase social security benefits by 10 percent, makes benefits automatically responsive to the cost of living in the future, increase the earnings base to \$9,000 in 1972, empower automatic adjustments to the wage base after 1972, and liberalize the earnings test. However, NALU opposes the section of the bill which would eliminate lower benefits to men retiring at age 62.

With respect to the remainder of the provisions in the bill, NALU will not express an opinion.

TEN PERCENT BENEFIT INCREASE

It is a well known fact that individuals maintaining a household by means of a fixed income are those individuals who are most affected

by the loss of buying power of the dollar as a result of inflation. The poignant letters received by the gentlemen of the committee is ample evidence of the havoc caused by inflation. There is little that I can add to the public knowledge about inflation. Suffice it to say that the people least able to bear the brunt of inflation are those on fixed incomes such as social security.

The Consumer Price Index tells us that the cost of living has risen by approximately 8.8 percent since the last adjustment in social security benefits. By the time the mechanics of this bill are effectuated, it is estimated that the cost of living will have gone up about 10 percent. Therefore, it is logical to conclude that in order to retain their relative position to the economy, benefits must be raised 10 percent.

The important word, here, is "relative." The social security program was designed to accomplish a specific goal, and that is, to replace the basic, minimum income of people who are no longer able to earn income for themselves.

I believe that the program has by and large accomplished that goal. The only requirement that needs to be met on a continuing basis is to retain the relative position of benefits to the economy as a whole. The 10 percent increase in benefits, plus the features of the bill which I will discuss next, satisfy that requirement.

AUTOMATIC ADJUSTMENTS OF BENEFITS

It would appear that approximately every 2 years, the House Ways and Means Committee holds hearings on proposed amendments to the social security program. The dominant theme of the hearings usually revolves around an increase in social security benefits necessitated by the erosion of the value of the dollar by inflation. If a means could be found to make social security benefits automatically responsive to the cost of living, it seems to me such a feature would be highly desirable. Fortunately, H.R. 14080 contains such a provision. As contemplated by the bill, social security benefits would be increased automatically whenever the Consumer Price Index was 3 percent or more above the Consumer Price Index for the last "cost of living computation quarter."

Thus, if the cost of living rose, benefits would be increased. If the cost of living remained stable, benefits would remain at their then current level. NALU believes that the automatic adjustment of benefits provision of H.R. 14080 is desirable, realistic, and workable. We therefore endorse this provision and would urge that the Congress make it law.

I will now direct our testimony to the provisions of the bill which increase the wage base in 1972 and adjust it, automatically, thereafter.

THE WAGE BASE

If the concept of automatic benefit increases is valid, and we think it is, then it follows that an automatic method of paying for the increases is also valid. There are two methods of financing benefit increases without doing violence to the philosophy of the social security system as it exists today, and the way we think it should be maintained in the future. The two methods are increases in social security **tax rates**, and/or increases in the social security wage base.

A third alternative, resort to general revenues, has been advanced by some individuals. NALU believes that such a solution to the problem of benefit financing would help to undermine the integrity of the program in the minds of American workers. It is our fervent hope that a stable, reliable social security system will be the legacy we will give to the generation of workers who come after us.

INCREASE IN WAGE BASE EFFECTIVE IN 1972

NALU believes that automatic adjustment of the wage base will accomplish the end to which we aspire, namely, a stable Social Security program, provided the wage base in existence at the time the automatic feature becomes effective is the proper one, relatively speaking. The Social Security Administration has advised the committee that a wage base of \$9,000, effective 1972, will be the wage base needed to support the benefit structure contemplated by this bill and provide the basis for future adjustments in benefits and revenue. The Social Security Administration calculations are derived from a formula which is based upon 80 percent of total earnings in covered work subject to contribution. Since 1951 that ratio has been maintained, by and large.

Based on the projections of Robert Myers, Chief Actuary of Social Security Administration, 80.8 percent of projected total annual earnings in covered work subject to contribution will equal \$9,000 in 1972. We accept the projections of Mr. Myers as accurate; \$9,000, then, would be our definition of the "proper" wage base subject to social security taxes in 1972.

AUTOMATIC ADJUSTMENT OF WAGE BASE

With a proper wage base as a starting point, a mechanism for the automatic adjustment of the wage base to reflect relative changes in the total earned income of covered workers makes a great deal of sense. Henceforth, the workers of the United States can depend upon social security benefits keeping pace with the economy, and, at the same time, be assured that the financing of those benefits will be handled in a responsible, businesslike manner, devoid of the controversy that has surrounded the benefit increases in the past.

Business management will be able to look upon the social security program with confidence, knowing at all times what percentage of average earned income of workers reaching retirement will be replaced by social security payments. Private pension and retirement programs can then be correlated with social security to provide a greater measure of retirement security to the working public. And, yes, the average working man will know with certainty just how much economic security he must provide for himself if he is to enjoy the full measure of his retirement years.

LIBERALIZATION OF EARNINGS TEST

In completing our statement insofar as the provisions of the bill which NALU supports, I would like to comment on section 5(a) (1) (2). That section is concerned with the liberalization of the so-called "earning test" or "work clause." The bill calls for an increase in the amount a retired worker, age 65 to 72, may earn in any given month

before affecting his social security benefits for that month. The amount is raised from \$140 per month to \$150 per month.

We favor the liberalization of the earnings test that is proposed here, from \$140 to \$150 a month.

We think that in light of past inflationary inroads into the value of the dollar, an increase of \$10 per month in earnings allowed under the earnings test is reasonable and in keeping with the spirit of this bill. NALU endorses this section of the bill.

AGE 62 COMPUTATION POINT FOR MEN

The final comments I wish to make regarding specific sections of H.R. 14080 concern the age 62 computation of benefits point for men, section 9. This section of the bill would provide that the ending point of the period that is used to determine insured status for men, and the ending point of the period that is used to determine the number of years over which a man's average monthly earnings must be calculated will be the beginning of the year in which he reached 62, instead of age 65, as is provided under present law. The rationale behind this proposed change in computation point is that women have been given the age 62 computation point and, therefore, to be fair, men should be afforded the same treatment. NALU believes that this rationale, at best, is suspect. We believe that this is the type of gradual overexpansion of the program to which we most strenuously object.

We cautioned in the past that there was no reason why, outside of disability, early retirement is beneficial. And we urged in the past that if such treatment were extended to women, it would serve as precedent for like treatment for men. The committee now has before it such a proposal, a proposal which we believe is unnecessary and undesirable.

In view of the increased life expectancy and useful economic life of the average American, we feel that to the extent that any further reduction in the eligibility age would operate to induce covered workers to choose, or be forced into, earlier retirement, such a result would tend to be detrimental both to the best social and economic interests of the workers themselves and to the economic growth of the Nation.

We think, in light of the needs of the employees and the needs of the country, this would force more people out of work at 62 instead of 65, and be an incentive to take people off the productive payrolls, if we had the 62 method of figuring rather than the 65.

I know personally we have had some concern among female employees who don't want to retire at 62, when the company plan now ties into social security and allows retirement at 62.

We have had among older employees much better life expectancy lately, and a reduction of their employability would not be in the public interest.

Therefore, we respectfully urge that section 9 of the bill not be adopted.

Gentlemen, as you can discern from our testimony, we are, generally speaking, in favor of the major provisions of H.R. 14080. However, our support of the bill should not indicate to the committee NALU's abdication of its role as friendly critic of the social security program. Rather, our testimony should be considered as one more example of NALU's continuing interest in the program, an interest which requires that we constantly work for the improvement of the system

within the bounds of philosophy appropriate for a social insurance system.

INDEPENDENT REVIEW AND STUDY OF THE SOCIAL SECURITY SYSTEM

In order to define the future role of social security, and unearth improvements which may help to round out the program, NALU wishes to renew its request to the committee that a high-caliber study committee be established to make a comprehensive review of the goals, priorities, and costs of the social security program. We believe that such a committee should be made up of experts from all sectors of the economic spectrum, both private and public.

We would hope that appropriate analysis of the role of private retirement benefits would be included as part of any such study. The role of the private sector and its present and future impact on retirement programs should be thoroughly studied prior to an expansion of the public role beyond reasonable boundaries. We hope, therefore, the Congress will consider the very real relationship between private and public benefits, and refrain from expanding social security to unreasonable limits that might impede the growth of private pension plans and other retirement programs.

We further contend that a thorough examination of the social security program would serve to properly focus the attention of Congress on the objectives and purposes of the system and, in so doing, remove inequities and restore a better balance between contributions and benefits.

We would favor a national study of the long-range effects of social security.

Mr. BURKE. Does either of your associates wish to testify?

Mr. MEEHAN. No, Mr. Chairman.

Mr. VANIK. Mr. Chairman?

Mr. BURKE. Mr. Vanik.

Mr. VANIK. I would like to ask this question.

You represent the National Association of Life Underwriters. What is the cost of coverage for death benefits and family support benefits under social security. What is the cost of this comparable coverage through a private carrier?

Mr. MEEHAN. Well, as I understand social security, 78-percent of the money goes for retirement benefits and 22-percent goes for death benefits.

Mr. VANIK. The problem that I constantly get is that the young people of America are very much concerned about social security, because they feel that they are carrying the great cost of taking care of the elderly.

I point out to them that I know of no private insurance anywhere in the United States that provides coverage, death-benefit coverage, to a family if we just consider that feature alone for as low a premium as they pay for their total social security payment.

Is that a correct statement?

Mr. MEEHAN. I would have to bring you an actuarial study of that in order to answer that accurately. To give you my best guess, I would say that we could provide a low-premium form of term insurance with similar coverage if we had 22 percent of the money that is going into social security.

Mr. VANIK. That is not the question. The question is, is there available today to the young people of America, the young workers of America, is there available in the whole spectrum of private industry, let's say for those people who can't be covered under social security, anything that can insure and provide a man death insurance and family support insurance for anything near the premium that is today paid for social security benefits, considering both the employee's contribution and the employer's contribution?

Mr. MEEHAN. Well, I could answer that by saying "yes."

Mr. VANIK. What is the policy? And tell me where I can get it, because I have to answer this question and I want you to tell me.

Mr. MEEHAN. At age 25, \$100,000 worth of decreasing term insurance in a fine company would cost about \$200 a year. I think that would provide more coverage for the young family than the present social security benefits.

Mr. VANIK. Will you document that?

Mr. MEEHAN. I will be glad to send you an illustration.

Mr. VANIK. And provide me with who has the coverage and what the premium rate is. And give me some analysis as to how the coverage compares with the coverage that such a young family gets under social security.

Mr. BETTS. Would the gentleman yield?

Mr. VANIK. Certainly.

Mr. BETTES. I think it would be helpful to have that in the record, if you can do that.

Mr. MEEHAN. I will be glad to provide that, and we will get that promptly to the committee for the record.

Mr. BURKE. Without objection, we will leave the record open for that.

(The following information was received by the committee:)

COMPARISON 1 OF SURVIVORS' BENEFITS UNDER SOCIAL SECURITY AS CONTEMPLATED BY THE SOCIAL SECURITY AMENDMENTS OF 1969 WITH DEATH BENEFITS OF COMMERCIALLY AVAILABLE LIFE INSURANCE CONTRACT PURCHASED WITH THAT PORTION OF OASDI TAX WHICH IS ALLOCATED FOR SURVIVOR BENEFITS

SOCIAL SECURITY								
Portion of OASDI tax allocated for survivor benefits ²	Mother's benefit	Child's benefit	Maximum monthly family benefit	Widow's benefit at age 62	Monthly family income, 13 years	Monthly family income, 2 years	Monthly widow's benefit beginning at age 62	Total income received ³
	75-percent PIA = \$817.50 per month.	75-percent PIA = \$187.50 monthly.	\$480	82½-percent PIA = \$205.25 monthly.	\$480	\$375	\$205.25	\$131, 625
COMMERCIALLY AVAILABLE LIFE INSURANCE CONTRACT ⁴								
Premium ⁵	Distribution of policy proceeds		Monthly family income, 13 years ⁶	Monthly family income, 2 years ⁷	Monthly widow's benefit beginning at age 62 ⁸	Total income received ⁹		
\$203.62 annually -----	No direct correlation with social security. Proceeds of contract paid out under settlement options which have no direct relationship to family makeup.		\$480	\$375	\$1, 233	\$338, 899		

¹ Comparison is based upon family unit consisting of fully insured husband age 25 at death, wife age 22, children ages 5 and 2 years. Husband assumed to earn maximum income subject to OASDI tax in 1972. Presumed to be \$9,000 annually.

² 1973 withholding rate used. Total tax withheld equal to 10 percent of payroll subject to tax. Of 10 percent withheld, 9.05 percent allocated to OAS. Of 9.05 percent withheld for OAS, 25 percent of 9.05 percent allocated for survivor benefits.

³ Female age 62 has life expectancy of 16.81 years. 1958 CSO commissioners standard ordinary life expectancy table.

⁴ Jefferson Standard Life Insurance Co., Greensboro, N.C. Contract illustrated is 20-year executive decreasing term insurance. Figures extracted from Diamond Life bulletins, 420 East 4th St., Cincinnati, Ohio.

⁵ Premium will purchase contract with 1st-year death benefit of \$100,354.

⁶ Settlement option No. 1 chosen to compare exactly with social security benefit period.

⁷ Settlement option No. 1 chosen to compare exactly with social security benefit period.

⁸ Single premium life annuity, 10 years guaranteed.

⁹ Calculations based upon the following formula: (a) Proceeds of insurance contract \$100,354. (b) Discounted value of 13- and 2-year benefit periods \$71,010. (c) Balance of \$29,344 invested at 5 percent annual compound interest for 40 years. Accumulation at end of 40 years \$296,581. Accumulation used to purchase single premium life annuity, guaranteed 10 years based on current rates. Female age 62 life expectancy 16.81 years.

Mr. VANIK. I take it that you support the administration's proposal to cut out, to reduce the inflow into the social security trust fund of \$22¼ billion by the provision which defers the already enacted increase in the social security contribution.

Do you think that is a good idea? Is that an actuarially sound idea?

You see, if the fund is left alone, we will have \$75 billion in that fund in just 4 years, and under President Nixon's plan we are going to have \$22¼ billion less. We will have \$56 billion.

Now, as an underwriter, do you think that it is sound business to reduce the size of this fund in this dimension?

Mr. MEEHAN. Well, you see, social security has one thing going for it that a private institution doesn't have. It has a guaranteed source of new, young people coming in with their money every year. So social security doesn't need to be fully funded, fully, let's say, secured, in order to deliver the benefits it is now delivering.

So from what you tell me, this fund would be reduced by \$22 billion in 4 years. The actuary for social security, Mr. Myers, has indicated—

Mr. VANIK. You are the best comparative source that we have as to the soundness of our actuarial information. Mr. Myers thought just a few years ago that we needed this \$75 billion reserve. Today the argument is that we don't need it.

Now, I want to ask you this as an independent actuary and having the problem of making insurance sound.

I want to commend that portion of your testimony that talks about the soundness of the fund, and I want to commend your organization very highly for recommending that we have an independent study made of the social security system. I want to go further than that. I want to go much further than that.

I want to see a proper investment of social security funds. I want the social security funds to be invested in the same broad spectrum of sound investments that the life underwriters have. I think it is stupid and ridiculous, I think it is cruel that we should impose upon our resources today a system in which we invest their money for as low as 4¼ and 3⅝ percent and some of the rates that are being brought in on those low-yield Federal bonds.

I think we ought to have some of that 8-percent investment. You have investment that runs 10 and 12 and 15 percent, and I think, frankly, that there ought to be more latitude in what the social security funds can invest in.

Do you agree with that or not?

Mr. MEEHAN. I would agree with that because that would reduce the cost if you could get a bigger return on the social security investments so that you could increase the benefits.

Mr. VANIK. It would reduce the cost or increase the benefits.

Mr. MEEHAN. And it might also keep pace in some degree with the cost of living, because at the present time you can get 8 percent in very sound investments at a time when the cost of living has gone up.

Mr. VANIK. The fears that the insurance industry had a few years back about the effect of social security have pretty much melted away. Actually, you have people today who are insurance conscious who were not.

Hasn't your market for the sale of life insurance grown throughout the period since we have started social security?

Mr. MEEHAN. Well, in selling life insurance—and I have been in the business 20 years—we always started with social security as the floor of protection and sold the additional insurance necessary for the family's needs.

Mr. VANIK. But actually it has stimulated the sales of insurance, hasn't it?

Mr. MEEHAN. I think it can be answered affirmatively by many people and negatively by a few people.

Mr. VANIK. I thank the gentleman.

Mr. BURKE. There being no further questions, on behalf of the committee I wish to thank you for your testimony. As has always been the custom with you, you have presented excellent evidence here on your side.

Mr. MEEHAN. Thank you very much, sir.

Mr. BURKE. Our next witness is Herman D. Stein. Is Mr. Stein in the room?

Mr. Vanik?

Mr. VANIK. Mr. Chairman, I think Mr. Stein planned on testifying this afternoon and didn't realize that we were going to conclude. You plan on concluding the hearing at this time, don't you?

Mr. BURKE. Yes.

Mr. VANIK. Under the circumstances, I would have to ask unanimous consent that Mr. Stein be permitted to place his statement in the record as though it had been read.

Mr. BURKE. Without objection, it is so ordered. (See p. 716 for telegram received from Mr. Stein.)

The committee has completed its work for today, and we stand adjourned. We will meet tomorrow morning at 10 o'clock.

(Whereupon, at 12:40 p.m. the committee adjourned, to reconvene at 10 a.m. on Wednesday, November 5, 1969.)

SOCIAL SECURITY AND WELFARE PROPOSALS

WEDNESDAY, NOVEMBER 5, 1969

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The committee met at 10 a.m., pursuant to notice, in the committee room, Longworth House Office Building, Hon. Wilbur D. Mills (chairman of the committee) presiding.

The CHAIRMAN. The committee will please be in order.

Our first witness this morning is our colleague from Hawaii, Hon. Spark M. Matsunaga.

Mr. Matsunaga, we are glad to have you back before the committee again, and you may proceed.

STATEMENT OF HON. SPARK MATSUNAGA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF HAWAII

Mr. MATSUNAGA. Mr. Chairman and members of the committee, I thank you for this opportunity of presenting my views on pending legislation which would increase social security payments and generally improve the social security program. I have introduced and cointroduced several bills which come within the scope of these hearings, and I shall identify them during the course of my testimony.

It is clear, from the most cursory examination of the social security and welfare proposals introduced in the present session, including the administration's welfare plan, that the need for improvements in the social security program is widely recognized. There appears to be some difference of opinion, however, as to the nature and extent of the needed improvements and as to the time when they ought to be instituted.

Social security payments are the major source of income today for some 25 million Americans. The number of recipients seems to be growing yearly as the average life span of humans is lengthened and more of our workers join the ranks of the retired. The elderly who depend solely on their social security check to defray current living expenses have found the benefits to be totally inadequate to meet even the minimum needs of life. The Department of Labor has pegged a "moderate" living standard at \$4,200 a year for a retired couple. An estimated 10 million retirees are reportedly kept above the poverty line by their social security benefits. However, it takes very little imagination to picture the plight of the millions of other elderly Americans, who, even with their social security payments, are forced to live in want and despair after completing their working years. Surely, our senior citizens deserve better in their declining years.

(1659)

To meet this clearly demonstrated need, Congress must provide dramatic and significant increases in benefits under the old-age, survivors, and disability insurance program of the Social Security Act. Anything less would fall far short of our goal of elevating our elderly Americans to the desired level of self-respect and dignity. Of the several pending bills, I believe that H.R. 14430, H.R. 14431, and H.R. 14432, the comprehensive bills introduced by the distinguished member of this committee, Mr. Jacob Gilbert, and a number of cosponsors, including myself, would do the job most effectively.

THE "SOCIAL SECURITY AMENDMENTS OF 1969"

The main thrust of the Gilbert bill, also cited as the "Social Security Amendments of 1969," is found in its provisions which would provide two increases of 20 percent across the board, the first beginning January 1, 1970, and the second beginning January 1, 1972. The first 20-percent increase would also raise the minimum benefit payment from \$55 to \$90; and the second 20-percent increase would also raise the minimum to \$120. After both increases are effectuated, the benefit amount based on average monthly earnings of \$510 would be raised from the present \$179.70 to \$258.90.

ANCILLARY BENEFITS

Other benefits provided by this legislation would :

A. Raise the special age-72 payments from the present \$40 a month to \$48 in January 1970, and to \$57.60 in January 1972;

B. Increase the maximum lump-sum death payment from the current \$255 ceiling, which has been in effect for the past 17 years, to \$500 beginning in January 1970; and

C. Raise the widow's benefit, effective January 1970, from the present 82½ to 100 percent of the worker's benefit where the widow's benefit begins at age 65 (there would be a reduction to 82½ percent if her benefit should begin at age 62).

RETIREMENT EARNINGS

The Gilbert bill would also update the amount that a person may earn in a month and still receive full social security benefits. The present exempt amount of \$140 would be raised by \$10 to \$150, which means that the annual exempt income would be \$1,800, effective January 1970. Rather than being a liberalization of the earnings test, this provision reflects an adjustment based on recent increases in wages and prices.

For the first \$1,200 of earnings above the annual exempt amount, the present withholding of \$1 of benefits for each \$2 of earnings would be unchanged. However, earnings exceeding the initial \$1,200 subject to withholding would call for the withholding of \$3 in benefits for each \$4 of earnings. At no point would \$1 in benefits be withheld for each \$1 of earnings.

COST-OF-LIVING ADJUSTMENT

An automatic adjustment of benefits, including regular social security and the special age-72 payments, would be provided whenever

there are annual cost-of-living increases of at least 3 percent. This provision would become effective in January 1973, and is expected to contribute greatly to the sense of security of our senior citizens.

This provision for a cost-of-living adjustment is found in the Federal Civil Service Retirement Act and in many retirement plans in private industry, and should be made a part of the Social Security program.

DISABILITY BENEFITS

The provisions under which present social security disability benefits are paid can hardly be called humanitarian or realistic. Such benefits are now payable only if the disability is expected to last at least 12 months and only after the worker has been totally disabled throughout 7 consecutive calendar months.

The Gilbert bill would make it possible for the worker to begin receiving disability benefits in the fourth month of disability by substituting a 3-month waiting period in lieu of the present 6-month period, effective in July 1970. The current harsh requirement that the worker's disability must be expected to last at least 12 months or end in death, would be eliminated.

To help bridge the gap between workers who are totally disabled and older handicapped workers who presently do not qualify for disability benefits, this legislation would provide, effective in July 1970, monthly disability benefits to handicapped workers age 55 and over, who can no longer perform their regular work or other work they have performed in recent years. The 3-month waiting period would also apply to these older handicapped workers.

Recognizing the need of totally disabled widows below age 50 for benefit protection, this legislation would also eliminate, effective January 1970, the age 50 and over requirement in existing law.

The further extension of disability benefits for the blind is found in my bill, H.R. 10465, and I shall comment on that proposal later in my testimony.

MEDICARE

Medicare would be expanded and strengthened by a plan, to become effective in July 1970, which would finance the hospital insurance and the medical insurance parts of the program with contributions paid by employees, employers, and the self-employed, with a matching contribution by the Federal Government from general revenues. Everyone who qualifies for hospital insurance would also qualify for supplementary medical insurance.

Another significant improvement to the medicare program is the extension of health insurance protection to the disabled which this bill would provide. Commencing in January 1972, hospital insurance and supplementary medical insurance protection would be extended to social security disability beneficiaries. This extended protection would be financed in the same manner proposed for health insurance for the aged: Payroll contributions by employees, employers, and the self-employed, along with a Federal matching contribution from general revenues.

As protection against today's high cost of drugs, the Gilbert bill would also provide coverage of prescription drugs.

H.R. 287: HEALTH INSURANCE BENEFITS FOR THE DISABLED

If our national health insurance program is to be meaningful, and if it is to be made available to those whose need for such protection is greatest, then it is necessary that title XVIII of the Social Security Act be amended to extend health insurance benefits to all disabled persons.

Both the Gilbert bill and H.R. 287, a bill that I introduced on the opening day of this Congress, provided for health insurance benefits for the disabled. For the young who are disabled, the Gilbert bill would extend medicare benefits to those who have attained age 18 and are entitled to child's insurance benefits under existing law. H.R. 287 would extend the health insurance benefits to individual over 21 who are disabled, regardless of entitlement to monthly cash benefits. The minimum age of 21 years required in H.R. 287 was intended to extend the health benefits to disabled workers who have reached the age of majority, which is 21 years in most States, but who may not be eligible for social security benefits under existing law.

If it is clearly the intent of the proposed legislation to provide health insurance for all disabled persons who need but are not presently covered by insurance, then there ought to be no restriction as to age. In recognition of the increasing difficulty among young and old alike to meet ever rising medical expenses I would recommend that the Gilbert bill relating to health insurance for the disabled be extended to cover beneficiaries irrespective of their age or entitlement to social security monthly benefits.

FINANCING

The cash benefits part of the social security program appears to be on a sound fiscal basis. Recent evaluation of the program by the actuaries of the Social Security Administration reportedly shows a surplus of 1.16 percent of taxable payroll. The added cost of the improvements in the Gilbert bill would be met out of an increased \$15,000 contribution and benefit base, with an automatic adjustment provision, and a gradually increasing Government contribution, which eventually would be equal to about one-third of the total cost of the cash benefits program.

Since the proposed second 20 percent benefit increase would not be effective until 1972, it is expected that rising wage levels would enable the program to continue on an actuarially sound basis.

H.R. 10465: TO LIBERALIZE ELIGIBILITY OF BLIND PERSONS TO RECEIVE SOCIAL SECURITY DISABILITY INSURANCE BENEFITS

The blind person occupies a peculiar place in our working world. While his handicap does not carry a social stigma, he nevertheless experiences considerable difficulty in finding steady employment. If he is fortunate enough to be hired, his work generally is on a project basis and comes to an end after a few weeks or a few months, with long gaps between periods of employment.

Recognizing the need to accelerate a blind worker's eligibility to receive benefits under the Social Security Act, every Congress since the 88th Congress has considered, but failed to enact, legislation which

would liberalize the condition governing eligibility of blind persons to receive social security disability insurance benefits. On April 23, 1969, I introduced H.R. 10465, a bill which again draws our attention to this very urgent problem.

The first of the two major provisions of this legislation would allow a blind person to qualify for disability benefits after he has worked six quarters in social security-covered work, instead of 20 of the last 40 quarters as presently required.

Secondly, his disability benefits would continue, irrespective of earnings, as long as blindness lasts. This latter provision recognizes the fact that a blind person functions at a financial disadvantage in a sight-structured world. The additional financial assistance would enable him to hire sight and thereby to reduce to some extent the economic disadvantages and inequalities of blindness.

I strongly urge that this legislation be given favorable consideration by this committee, for I am confident the House would readily approve it.

H.R. 7487: TO EXTEND AND IMPROVE FEDERAL-STATE PROGRAM OF CHILD-WELFARE SERVICES

Legislation to amend title IV of the Social Security Act so as to extend and improve the Federal-State program of child welfare services was introduced in the 90th Congress and was considered by this committee in 1967 in connection with proposed revisions to the Social Security System. I respectfully urge that this legislation, which would provide adequate and comprehensive child welfare services at the State level, be included in the Committee's reported bill of social security amendments in this Congress.

My bill, H.R. 7487, introduced on February 24, 1969, would provide for comprehensive child welfare services for America's children, the single most important resource on which the future of this Nation depends. By means of legislation such as H.R. 7487, adequate Federal funds would be made available for an improved child welfare program. Each State, after developing a plan for a comprehensive child welfare program which meets Federal requirements, would receive Federal assistance in an amount equal to 75 percent of the salary and training costs for child welfare personnel.

In addition, the Federal Government would pay, on a matching basis, depending on a State's per capita income, a percentage of the cost of all child welfare services for every child who is the responsibility of the State or local public welfare agencies. This percentage would be at least 50 percent but no more than 83 percent.

Finally, new project grants are also provided to encourage States to develop new forms of child welfare services.

H.R. 285: TO PERMIT FEDERAL EMPLOYEES TO ELECT SOCIAL SECURITY COVERAGE

Mr. Chairman and members of the committee, social security has become a very important part of life in the United States. It has, since it was first instituted during a particularly dark period in the economic life of this Nation, extended its protection to a growing

number of Americans. Consistent with this trend, H.R. 285, which I introduced, and similar legislation introduced by other members, would extend to Federal employees, based on their own determination of need, the option of electing social security coverage.

A Federal employee who wants social security could at any time within 2 years of the date that the bill is enacted, or within 2 years after he obtains a Federal job, elect to have his Federal employment covered under the social security program. If he elects to do this, he would pay social security taxes like any other employee, and if he becomes disabled, retires, or dies, social security benefits would be available to him or to his family in addition to any benefits that are provided under the existing program for Federal employees.

This legislation is not intended to place Federal employees in a favored status. It would merely grant to them the same privilege of enrolling in our social security system which is presently available to private industry workers, many of whom have excellent pension plans, and to many State and local civil servants.

Mr. Chairman and members of the committee, the idea embodied by H.R. 285 I think is a good one, and a workable one. It is the next logical step forward which ought to be included with other proposals to improve the Social Security Act. I therefore strongly urge that the provisions of H.R. 285 be included in the Social Security Amendments of 1969.

The CHAIRMAN. Mr. Matsunaga, we appreciate very much your excellent statement.

Are there any questions?

If not, again we thank you.

Mr. MATSUNAGA. Thank you, Mr. Chairman.

The CHAIRMAN. Our next witness is our colleague from New York, the Honorable Jonathan B. Bingham.

Mr. Bingham, we appreciate very much your coming to the committee on this very important legislation. You may proceed.

STATEMENT OF HON. JONATHAN B. BINGHAM, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. BINGHAM. Thank you, Mr. Chairman.

The subject matter that the committee is considering in these hearings is so broad that I will not attempt to cover more than a few points.

First, a few general remarks with regard to social security. The President has stated that he is willing to consent to a 10 percent rise in social security benefits, and cost of living adjustments thereafter. This is an improvement from his position that a 7-percent increase would be adequate, but it is not nearly enough. One of the worst features of the President's position is that he supports a cost-of-living escalation clause on an inadequate base. I believe it is vital to adjust benefits to be consistent with the cost of living, but if that is done without a sufficient increase in the basic rate, there is a danger that benefits will be too low forever, rising occasionally but always too little. If that inadequate remedy were in effect, the likelihood of getting any other changes would be decreased.

I strongly urge the committee not to adopt an escalator clause unless the basic rate is substantially increased.

On March 19, I introduced H.R. 9221, which called for a number of improvements in the social security system that would begin to provide for our older people the kind of benefits which they ought to have in light of the resources of this country. My bill would raise average benefit rates by 35 percent, and would establish a retirement income minimum of \$100 a month for an individual and \$150 a month for a couple. It would provide average benefits of \$133 a month for individuals and \$220 a month for couples.

My bill also provides for an automatic cost-of-living adjustment which would increase social security benefits each year to keep pace with rising consumer prices. Under my bill, this provision would be in addition to an adequate increase in benefits, not a substitute. To provide further assistance for the many retired individuals who find it necessary to continue working to make ends meet, my legislation provides that the current limit on earnings permitted each year without penalizing deductions from benefits be increased from the current \$1,580 to \$3,600.

There are a number of other provisions in this bill which, though more limited in impact, are nevertheless significant for those who would be affected by them. For example: First, dependent parents of social security recipients should be eligible for benefits, just as other dependents now are; my legislation would make them eligible; second, an individual over 65 who is still employed should have the option of continuing his contribution to the social security system to raise his future benefits, or to halt his contributions and thereby freeze his benefit level at the age 65 figure; this legislation would provide that option; third, the inequities against working wives who are forced to choose benefits based on either their own wages or on their status as a wife should be replaced by a method of pooling credits; my legislation would allow such pooling; fourth, those over 65 who receive benefits as widows or widowers should not be penalized because of their subsequent remarriage, and this legislation would end such penalties.

Recently, my colleague from New York, Mr. Gilbert, a member of this committee, introduced H.R. 14430. I congratulate Mr. Gilbert on the extensive job he has done on this bill, and I am happy to be among its cosponsors. I urge the committee to report it favorably.

Turning to the subject of medicare, there are many areas in which the present legislation should be improved. In H.R. 9221, I have emphasized the need to include the cost of certain prescription drugs under the medicare program. The difficulties for many older Americans posed by the exclusion of these drugs from medicare coverage have been clearly illustrated in extensive congressional hearings. My bill would extend part B benefits of medicare, for the extra cost of \$1 per person per month, to prescription drugs, thus relieving the elderly of the crushing burden of drug costs.

In my judgment, there is no reason why the cost of these drugs should be higher than what would be required to purchase generic drugs. Neither those on social security nor any other taxpayer should be expected to pay the additional cost of making brand-name drugs available. If doctors insist on prescribing brand-name drugs, that is a matter to be settled between them and their patients. But the additional cost should be paid for by the patients.

I concur on Mr. Gilbert's recommendation that the committee study this question thoroughly. I hope that the committee will devise an

approach so that savings may be realized through use of low-cost generics.

Turning now to the broad subject of welfare reform, there can be no question that the present system needs to be drastically revised. I think the President is to be complimented on moving in the direction of a system which will eliminate the present tendency toward breaking up families and will provide better and more effective work incentives. While the President's plan properly calls for a greater degree of Federal responsibility and set minimum Federal standards, the standards proposed are far too low to be realistic. Not only should the basic standards be raised, but provisions should be made for the Federal Government to pay at least half the cost of higher standards set by individual States. Moreover, regional cost-of-living differentials should be provided, and some provisions should be made for individuals, childless couples, and couples with grown children, as well as families with small children.

These and other matters are dealt with in H.R. 13476, which was jointly introduced by Congressmen Conyers, Whalen, Ryan, and myself on August 12, 1969, providing for a national living income plan. Without going into detail on that proposal, I commend it to the committee's attention.

In conclusion, I should like to say that I believe all of us in Congress would do well to seek a more vivid understanding of what it means to be on welfare in the several States. In July, at the invitation of the New York Citywide Coordinating Committee of Welfare Groups, my wife and I lived for a week on the amount allowed for food under the New York welfare system, namely 66 cents a day per person, or 22 cents a meal. My wife went to great trouble to plan meals that would be cheap and nutritious at the same time. I should like to submit for the record the precise list of the items we consumed during the week, totaling \$9.34, and the menus my wife worked out.

Even with such careful planning, drawing upon a college education, some knowledge of nutrition and advice from our grocer and from a welfare client adviser, the meals were not only boring, but unsatisfying. We were hungry a lot of the time, because starchy foods do not "stick to the ribs," and we also felt a loss of energy and initiative. It is especially tragic, it seems to me, that people on welfare, who need initiative and energy to improve their lot, should be precisely the ones to suffer a loss of these assets.

A number of our colleagues in the Congress, including Senators Church, Eagleton, Harris, Hart, McCarthy, and Mondale and Representatives McCloskey and Mikva went through the same experience, with their families. For those with small children, it was especially painful. And of course the amounts available under most State plans are substantially below the figure for New York, so these families had a harder time than my wife and I did.

I would respectfully suggest to the chairman and members of this distinguished committee that they try the same experiment. They will find the experience disagreeable but enlightening. I would like to append to my testimony a list, prepared by the National Welfare Rights Organization, of the amounts available for this purpose under the welfare program of the 50 States. Although the figures may vary from community to community within each State, they give a pretty good idea of what Members can expect from a welfare meal.

*Expenses of Representative and Mrs. Jonathan Bingham on welfare diet,
July 17-23, 1969*

<i>Food:</i>	<i>Cost</i>	<i>Food—Continued</i>	<i>Cost</i>
Grapefruit juice -----	\$0.41	Margarine— $\frac{1}{2}$ lb.-----	\$0.15
Quaker oats $\frac{2}{3}$ of 65¢ box-----	.45	Teabags (2) -----	.03
Coffee -----	.89	$\frac{1}{2}$ lb. onions (10¢ a lb.)-----	.05
Powdered milk—2 qt.-----	.30	$1\frac{1}{2}$ packs Kool Aid-----	.15
Rice— $\frac{1}{2}$ box -----	.10	$\frac{1}{2}$ pack cigarettes-----	.20
Peanut butter— $\frac{1}{3}$ jar -----	.15	Spaghetti -----	.10
Syrup— $\frac{1}{4}$ bottle (25¢)-----	.09	6 eggs -----	.30
Jelly— $\frac{1}{2}$ jar -----	.16	Self-rising flour— $\frac{1}{2}$ lb.-----	.09
1 bunch of carrots-----	.15	Pancake flour—1 cup-----	.15
Bananas—4 speckled -----	.18	Ivory soap -----	.09
Orange—1 -----	.08	Toilet tissue -----	.10
$\frac{1}{2}$ price Sat. hamburger $1\frac{1}{4}$ lb.--	.50	1 soft tomato-----	.10
Veal kidney (1 lb.)-----	.41	Detergent -----	.15
Chicken wings and 2 drumsticks--	.50	Jello -----	.10
Beef bouillon cubes (5)-----	.10	Dried limas -----	.30
Chicken bouillon cubes (5)-----	.10	1 lemon -----	.05
Tomato juice for cooking-----	.19	1 salad gelatin-----	.10
Worcestershire sauce $1\frac{1}{4}$ oz.---	.20	Cheese—6 oz. American-----	.40
Tuna (1 can)-----	.39	Salt—pepper—sugar -----	.04
Mayonnaise -----	.20	Baked beans—can -----	.18
Aspirin -----	.10	Canned mackerel -----	.29
Bread -----	.25		
Mazola— $\frac{2}{3}$ bottle (47¢) -----	.32	Total cost -----	9.34

Food obtained free: trimmings from lettuce, cabbage, celery, soup bones (marrow used for gravy), 2 broken green peppers.

MENUS

7 Breakfasts:

6 days, grapefruit juice, oatmeal, powdered milk, coffee

Sunday, tomato juice, pancakes with syrup, coffee

7 lunches:

Thursday, July 17:

1 peanut butter with jelly sandwich

1 tuna salad sandwich

1 banana for husband

Friday, July 18:

1 egg salad sandwich (husband)

1 french toast (myself)

1 raw carrot (husband)

1 parboiled celery (myself)

Saturday, July 19:

Chicken wings with rice

Braised lettuce

Sunday, July 20:

Meat loaf with oatmeal

Raw carrots

Monday, July 21:

Meat loaf sandwiches (1 for each of us)

Raw carrots

Biscuits with jelly

Banana for husband

Tuesday, July 22:

2 cheese and lettuce sandwiches (1 for each)

Parboiled celery

Wednesday, July 23:

2 tomato and cheese sandwiches (1 for each)

7 suppers:

Thursday, July 17:

Baked California Lima Beans—with tomato juice and onion, celery and carrot
Braised lettuce
Snack before bed—jello and biscuits

Friday, July 18

Veal Kidney with soup scraps
Spaghetti
Cooked lettuce

Saturday, July 19:

Baked beans
Raw carrot (lunch was larger than usual)
Banana and orange

Sunday, July 20:

Soup with rest of rice and lettuce (lunch large)
biscuit
Moon feast—cheese and biscuits
Cold meat loaf
Kool aid

Monday, July 21:

Mackerel cakes
Cabbage cooked in chicken bouillon
Biscuit

Tuesday, July 22:

Rest of Kidney
Rice and rest of beans
Gelatin vegetable salad

Wednesday, July 23:

pepper stuffed with rest of meat loaf plus gravy from soup fat

Note: Purposely avoided as not worth the money: luncheon meats, hot dogs.

AMOUNTS AVAILABLE, BY STATE, FOR FOOD, PERSONAL CARE, AND
HOUSEHOLD SUPPLIES, UNDER WELFARE PROGRAMS

	Per-person cost for 1 week	Cost per person per meal		Per-person cost for 1 week	Cost per person per meal
National.....	\$3.80	\$0.18	Missouri.....	\$2.50	\$0.11
Alabama.....	1.40	.06	Montana.....	3.50	.16
Alaska.....	4.20	.20	Nebraska.....	3.30	.15
Arizona.....	2.50	.12	Nevada.....	2.80	.13
Arkansas.....	1.70	.08	New Hampshire.....	4.00	.19
California.....	4.30	.20	New Jersey.....	5.40	.25
Colorado.....	3.60	.17	New Mexico.....	2.70	.13
Connecticut.....	5.80	.27	New York.....	5.90	.22
Delaware.....	2.90	.13	North Carolina.....	2.50	.11
District of Columbia.....	3.70	.17	North Dakota.....	4.30	.20
Florida.....	1.80	.08	Ohio.....	3.50	.16
Georgia.....	2.30	.10	Oklahoma.....	3.00	.14
Guam.....	3.10	.14	Oregon.....	3.60	.17
Hawaii.....	4.20	.20	Pennsylvania.....	4.40	.21
Idaho.....	4.20	.20	Puerto Rico.....	.60	.03
Illinois.....	4.30	.20	Rhode Island.....	4.60	.22
Indiana.....	2.90	.13	South Carolina.....	1.60	.07
Iowa.....	4.50	.21	South Dakota.....	4.10	.19
Kansas.....	4.20	.20	Tennessee.....	2.30	.11
Kentucky.....	2.60	.12	Texas.....	4.70	.08
Louisiana.....	2.10	.10	Utah.....	3.50	.16
Maine.....	2.70	.12	Vermont.....	4.40	.21
Maryland.....	4.50	.16	Virgin Islands.....	2.60	.12
Massachusetts.....	5.90	.28	Virginia.....	2.90	.13
Michigan.....	4.30	.20	Washington.....	4.40	.20
Minnesota.....	4.90	.23	West Virginia.....	2.30	.11
Mississippi.....	.80	.04	Wisconsin.....	4.90	.23
			Wyoming.....	3.50	.16

Source: National Welfare Rights Organization.

Calculations for the individual states' cost per welfare recipient, per meal, were based on the U.S. Bureau of Labor Statistics recent study on the *Living Standards*. Percentages were figured for amounts spent on each budget category (food, clothing, shelter, etc.). Food, household operations (paper towels, etc.,

phone), and personal care were grouped together in one "supermarket" category. The resulting percentages were then applied to the average monthly welfare grant per recipient for each state (HEW's bulletin of *Public Assistance Statistics*, January 1969). For instance, the average national AFD monthly grant per person is \$42.90. 39% of this, \$16.73, represents the amount that a person has to spend on this "supermarket" category. To figure the weekly grant for food, etc. the monthly amount is divided by 4.3 (weeks in month)=\$3.80. This can be divided by 7 (days) for a daily cost (\$.54) and again by three meals for a final cost per meal per person (\$.18).

The CHAIRMAN. Thank you, Mr. Bingham. We appreciate your taking time to give us the benefit of your views.

Are there any questions?

If not, thank you, again, Mr. Bingham.

MR. BINGHAM. Thank you, Mr. Chairman, and members of the committee.

The CHAIRMAN. We next have another of our colleagues, the Honorable James Kee of West Virginia, who is accompanied by a group of people interested in this legislation.

Come forward with your group, please, Mr. Kee.

STATEMENT OF HON. JAMES KEE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WEST VIRGINIA; ACCOMPANIED BY DR. ANDREW H. HENDERSON, WILLIAMSON, W. VA.; GEORGE J. TITLER, INTERNATIONAL VICE PRESIDENT, UNITED MINE WORKERS OF AMERICA; ODELL GWYNN, PRESIDENT, DISABLED MINERS AND WIDOWS ASSOCIATION; AND MR. AND MRS. CHARLES OMECHINSKI, QUINWOOD, W. VA.

MR. KEE. Thank you, Mr. Chairman.

The CHAIRMAN. We appreciate very much having you with us and bringing these fine people along.

MR. KEE. Thank you very much, Mr. Chairman.

Mr. Chairman and distinguished members of the Committee on Ways and Means of the U.S. House of Representatives, it is with a heart full of gratitude that I express to you and the distinguished members of your committee my highest admiration for your compassion in granting me the privilege of coming here to express my views on how the social program should be improved.

Mr. Chairman, your committee is the humanitarian committee of the Congress. It was your committee that had the foresight to establish the social security program. It has been through your committee, Mr. Chairman, that over the years the social security program has been liberalized, if you want to use that word, to help those in need.

I know the unsurpassed demands placed upon your committee and that you have had sufficient detail on the need for increasing social security benefits. Therefore—in order to save your time—I will not go into this part of the social security program but will confine my remarks to special pleading that you give careful consideration to my bill, H.R. 10499.

Mr. Chairman, this bill which would amend titles II and XVIII of the Social Security Act as drafted over a long period of time in order to provide disability insurance and hospital insurance benefits to people who are truly in need. Enactment of this bill would prolong and spare the lives of many individuals who are totally disabled and

suffering from fatal illnesses. My distinguished colleague, Mr. Saylor of Pennsylvania, has joined me in this humanitarian effort and from what I know of this committee—it is clear to me that you, too, care about those who are truly in need.

Mr. Chairman, one of the great tragedies facing many American homes occurs when the family breadwinner becomes totally disabled and unable to engage in any gainful employment. Under the present law, he may be found eligible for monthly cash benefits if he is unable to perform any substantial gainful activity. This definition which was written by your committee is, as you know, a stern test of disability. It provides the helpless with a small cash income with which to meet the recurring expenses of daily living. It does, however, provide no way of raising money to meet the extraordinary expenses connected with illness. Medical and hospital costs—as members of this committee are so painfully aware—are increasing faster than any other element that goes to make up the cost of living. The social security disability beneficiary has no way of raising money to pay these essential expenses. This I have seen countless times in my own district when a disabled person knows it is a physical impossibility for him to pay his essential hospital costs, he becomes deeply concerned and should he die, his widow and dependent children may be faced with hospital bills ranging from \$3,000 to \$16,000—an amount that is impossible for them to pay because of their limited incomes.

While H.R. 10499—which Mr. Saylor and I introduced on April 23, 1969—would liberalize the conditions under which disability insurance benefits are paid to coal miners afflicted with pneumoconiosis—popularly known as black lung disease—I have further reviewed this problem and recognizing that pneumoconiosis is a special interest to all coal-producing areas throughout the United States—I believe the definition should be broadened to encompass all working people—regardless of age—who incur lung disease caused by the inhalation of dust to which they are exposed in their working environment. These people, I believe, should be entitled to all the benefits which are presently available only to aged social security beneficiaries. Mr. Chairman—essentially what I am proposing is that the definition of disability which now applies to blind people age 55 and over be extended to all people with work-connected dust-caused diseases and that these benefits be paid to them regardless of age. I am told that this provision can be added to the social security program without any significant effect on the long-range cost of the program.

In addition, I would provide medicare benefits for all people, children disabled before age 18, disabled widows and widowers under 65, and disability insurance beneficiaries with the benefits of the medicare program. This is essentially the same proposal that former Secretary of HEW, Wilbur Cohen, made shortly before he left office. You will recall that his recommendation grew out of a study which was called for in the committee report on the 1967 Social Security Amendments. In making this recommendation, I realize that the present estimates show that the medicare program is woefully underfinanced, about .77 percent of payroll to which my provision would add about 0.6 percent—depending on the tax base used. While I would not presume to tell the experts of your committee how to solve this problem, I do believe, however, that there is a solution and I have every confidence that you will resolve this financial dilemma.

As I indicated earlier, my interest in this problem grew out of my concern for the coal miners in my State, as well as railroad employees, who are afflicted with pneumoconiosis. Recently, the Department of Health, Education, and Welfare estimated that there were more than 8,500 miners in West Virginia who are disabled because they have pneumoconiosis. All together, there are approximately 50,000 miners in the country so disabled.

Out of my concern for this relatively small number of people, when viewed in relation to the national population, grew my broader concern to extending my proposed amendment to all people afflicted with dust-caused diseases.

Mr. Chairman, I was born and raised in the Fifth Congressional District of West Virginia which is the largest coal-producing congressional district in the United States. Through my correspondence and public meetings which I have conducted throughout my coal-producing congressional district, I have found so many men under the age of 65 who are suffering lung disease and go to a much earlier grave because they do not have the financial resources to provide for essential hospital care. Therefore, it seems only reasonable to me that the medicare program be extended to individuals receiving cash benefits based on disability without regard to their age. This is the greatest need for America to provide the necessary help so desperately needed in numerous homes throughout the coal-producing areas of the United States.

Mr. Chairman, in August, a year ago, I toured the coal-producing areas of my district. I announced public meetings. I spent 2 days in each county, asked folks to come in to discuss whatever problems they had, and it was apparent that the paramount problem, Mr. Chairman, of many of these people was that they couldn't breathe. They would have trouble trying to walk up the steps. They would have to take them two at a time. Some of them actually literally had to be carried up the steps to talk to me, and they simply do not have the breath, Mr. Chairman, to stand any other sort of physical exertion.

The trouble is they need oxygen, adrenalin, or they need these other things to prolong their lives. There is no way in the world, Mr. Chairman, in which they can pay for the medical care they need.

Therefore, Mr. Chairman, this is primarily the reason for my introduction of H.R. 10499.

Mr. Chairman, at this point, I will be happy to attempt to answer any questions that you or your committee members may have.

The CHAIRMAN. Don't you think it would be better if those with you made their statements before we interrogate any of you?

Mr. KEE. Thank you.

The CHAIRMAN. If you will introduce them as you want them to make their statements, we will be glad to hear them.

Mr. KEE. Mr. Chairman, I am delighted at this point to present Dr. Andrew H. Henderson, of Williamson, W. Va. Dr. Henderson is a lung specialist, with 18 years experience. Dr. Henderson is a man of compassion. He is an excellent doctor. He became interested in this. He is the only doctor that I could find that would take time. He took 30 days from his practice in developing factual medical information on lung diseases. He went to a hospital where he practices,

the old Miners Memorial Hospital, which is now a community hospital, and for one solid year, Mr. Chairman, he went over the entire records of everyone that had been admitted to that hospital for a lung disease condition, and I might further state that he was by far the most effective witness before the Education and Labor Committee when the committee reported and the vote on the floor was 389 to 4 on the Coal Mine Safety, Health, and Compensation bill.

I think it is only proper to state that Dr. Henderson's statement did more to get that through the committee than any humble effort that I could make, sir.

Now, Dr. Henderson.

The CHAIRMAN. We are pleased to have you with us, Doctor, and you are recognized.

STATEMENT OF DR. ANDREW H. HENDERSON, WILLIAMSON, MINGO COUNTY, W. VA.

Mr. HENDERSON. Mr. Chairman, and distinguished members of the House Committee on Ways and Means, I am grateful for the opportunity to testify in behalf of H.R. 10499 which was introduced in the U.S. House of Representatives by Congressman James Kee of West Virginia and Congressman John P. Saylor of Pennsylvania.

I commend Congressman Kee and Congressman Saylor, as well as your committee, for considering this bill at this time and I fully support H.R. 10499 which provides for amendments to the Social Security Act to provide benefits to coal miners afflicted with pneumoconiosis, as well as to railroad employees.

It is my opinion that the coal miner, regardless of age, should be eligible for total disability benefits if he has at least 10 years employment in a coal mine and meets the criteria for permanent loss of lung function of at least 50 percent by the usual methods of testing.

In a recent study: "A Comparative Analysis of Lung Diseases in Patients Admitted to a Mining Community Hospital with Additional Comments," there was demonstrated for the year 1968 the comparable morbidity of lung diseases arbitrarily chosen to include pneumonia, emphysema, bronchitis, pneumoconiosis, asthma, tuberculosis, carcinoma of the lung, and bronchiectasis in the bituminous coal miner, whether active or retired, as compared to their counterparts in the remainder of the adult population in the mining community of south Williamson, Ky.

Information related to this study, as well as other information which I developed from a medical viewpoint, will be found in the latter part of my written statement so that you can evaluate same.

West Virginia mines produce more bituminous coal than any other State in the United States and the ratio of coal miners per total population is higher than any other State.

In a bulletin published by the U.S. Department of Health, Education, and Welfare, dated December 1967, labeled "Disability Allowances, Number of Persons for Whom a Period of Disability Was Allowed in 1965 and Percentage Distribution by Diagnostic Group by State," it was noted that West Virginia was highest of any State with 17.2 percent receiving social security benefits with the diagnosis of diseases of the respiratory system. The next highest was Arizona

with 16 percent. Since the population is decreasing in West Virginia many of those in Arizona with lung diseases may have migrated from West Virginia.

Another interesting statistic by the U.S. Department of Health, Education, and Welfare, dated March 1969, reveals the average of disabled workers to retired workers receiving social security in the United States is 9 percent. In West Virginia, this is 20 percent, in southern West Virginia in Logan County, a large coal producing county, this is 36 percent, and in Mingo County it is 33 percent. These figures were dated December 31, 1968 and compiled by the Social Security Administration.

The present criteria for receiving social security benefits for disability due to respiratory diseases as expressed in loss of lung function varies somewhat depending on the test being used. The average is 80 to 90 percent loss of lung function. It is a fact that a miner cannot work at any job with this much loss of lung function. He has to cease work at approximately 50 percent loss of lung function and this may be 4 or 5 years before his lungs have deteriorated to the loss required by law before he is eligible for social security benefits. It is a known fact that these men with coal miners pneumoconiosis deteriorate in lung function long after the exposure to the coal mine dust ceases. These men, after they cease work, for the most part, are not able to be rehabilitated and many spend the interim few years on State welfare.

SUMMARY

1. Evidence from hospital records demonstrates the marked increase in respiratory diseases in the active and retired coal miner compared to their counterparts in a coal mining community.

2. Social security records show that West Virginia, the largest coal mining State, has the highest percentage of social security recipients diagnosed with lung disease of all the States in the United States.

3. It is estimated that 4 percent of the miners working will require 2 weeks hospitalization for each coal miner per year due to lung disease.

4. The criteria for disability for lung disease for social security benefits are too rigid at this time for the coal miner.

5. It is strongly suggested that coal miners with 50 percent or more loss lung function should be eligible for social security benefits after 10 years employment in a coal mine.

6. H.R. 13950, after conferee consideration, will hopefully make suggestion No. 5 less needed because future safeguards should result in many less afflicted coal miners.

7. I again strongly suggest that the wording "Complicated pneumoconiosis" in H.R. 13950 be changed to "(lung disease) caused by exposure to dust during their employment, with 50 percent or more permanent loss of lung function." It appears that only 20 to 25 percent of men afflicted with severe lung disease would be eligible under other legislation because it is shown by this report that only approximately 20 percent have classical complicated pneumoconiosis and 80 percent have emphysema with just as much disability as those with complicated pneumoconiosis. This change in definition is of utmost importance relative to H.R. 10499.

The CHAIRMAN. Does that conclude your statement?

Dr. HENDERSON. Thank you.
(The attachments referred to follow :)

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I commend Congressman Kee and Congressman Saylor, as well as your Committee, for considering this bill at this time and I fully support H.R. 10499 which provides for amendments to the Social Security Act to provide benefits to coal miners afflicted with pneumoconiosis, as well as to railroad employees.

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In a recent study, "A Comparative Analysis of Lung Diseases in Patients Admitted to a Mining Community Hospital With Additional Comments,"¹ there was demonstrated for the year 1968 the comparative morbidity of lung diseases arbitrarily chosen to include pneumonia, emphysema, bronchitis, pneumoconiosis, asthma, tuberculosis, carcinoma of the lung, and bronchiectasis in the bituminous coal miner, whether active or retired, as compared to their counterparts in the remainder of the adult population in the mining community of South Williamson, Kentucky.

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Another interesting statistic by the U.S. Department of Health, Education, and Welfare, dated March 1969,³ reveals the average of disabled workers to retired workers receiving Social Security in the United States is 9%. In West Virginia, this is 20%, in southern West Virginia in Logan County,⁴ a large coal producing county, this is 36%, and in Mingo County it is 33%. These figures were dated 31 December 1968 and compiled by the Social Security Administration.

The present criteria for receiving Social Security benefits for disability due to respiratory diseases as expressed in loss of lung function varies somewhat depending on the test being used. The average is 80% to 90% loss of lung function. It is a fact that a miner can not work at any job with this much loss of lung function. He has to cease work at approximately 50% loss of lung function and this may be four or five years before his lungs have deteriorated to the loss required by law before he is eligible for Social Security benefits. It is a known fact that these men with coal miners pneumoconiosis deteriorate in lung function long after the exposure to the coal mine dust ceases.⁵ These men, after they cease work, for the most part, are not able to be rehabilitated and many spend the interim few years on State welfare.

¹ Submitted for publication, West Virginia Medical Journal, Sept. 5, 1969.

² Social Security Disability Applicant Statistics, December 1967.

³ Social Security Bulletin, Table Q-14, OASDHI, Cash Benefits, Etc., End March 1969.

⁴ Logan, W. Va., Social Security Office Statistics, Dec. 31, 1968.

⁵ Thoracic Diseases, Rubin, 1961, Page 704.

SUMMARY

1. Evidence from hospital records demonstrates the marked increase in respiratory diseases in the active and retired coal miner compared to their counterparts in a coal mining community.

2. Social Security records show that West Virginia, the largest coal mining State, has the highest percentage of Social Security recipients diagnosed with lung disease of all the States in the United States.

3. It is estimated that 4% of the miners working will require two weeks hospitalization for each coal miner per year due to lung disease.

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COMMENTS ON TABLES I, II, III, IV, AND V

1. 16% of all discharges were miners.

2. 12.89% of all discharges were miners with lung diseases.

3. 74.3% of all miners discharged had diagnosis of a lung disease.

4. Emphysema is four times more common in the active and retired miner than the non-miner male in hospital patients in this study (230-58). This is much more significant when it is noted that the miner (active and retired) makes up 16% of all hospital patients.

5. The lung diseases—pneumonia, bronchitis, pneumoconiosis, and carcinoma of the lungs are more common in miners than in non-miners.

6. The wives of miners have more emphysema than their counterparts. Perhaps this is because many live near the coal tipples.

7. The most common lung disease in the coal miner is emphysema.

8. It is estimated that 4% of active miners spend fourteen days per year in a hospital with diagnosis of lung disease.⁷

9. Emphysema begins to appear at age 35 years in the miner.

Table I.—Appalachian Regional Hospital, South Williamson, Kentucky, 1968

Table I shows a comparison of the number of cases of pneumonia, emphysema, bronchitis, pneumoconiosis (X-ray diagnosis), asthma, tuberculosis, carcinoma of the lung, and bronchiectasis, to the total number of patients taken from the diagnostic index file of the Appalachian Regional Hospital for the year 1968 at South Williamson, Kentucky.

1. Total all patients, except new-borns—5,053 discharges—47,482 hospital days—100% of total hospital discharges.

2. Miners (all diseases, including lung diseases) under 65 years of age—436 discharges.

3. Miners (all diseases, including lung diseases) over 65 years of age—373 discharges.

4. Total of No. 2 and No. 3—809 discharges—16% of total hospital discharges.

5. Active miners under age 65 (lung diseases)—213 discharges—174 patients—2,440 hospital days—5.01% percentage of total hospital discharges.

6. Retired miners over age 65 (lung diseases)—259 discharges—218 patients—3,717 hospital days—7.88% percentage of total hospital discharges No. 5 and No. 6 total 12.89% miners.

7. Active non-miners under age 65 (lung diseases)—52 discharges—40 patients—859 hospital days—1.80% percentage of total hospital discharges.

8. Retired non-miners over age 65 (lung diseases)—93 discharges—71 patients—1,218 hospital days—2.56% percentage of total hospital discharges No. 7 and No. 8 total 4.36% non-miners.

⁶ Social Security Regulations, August 1968, 3.01 Category of Impairments, Respiratory.

TABLE II.—A BREAKDOWN OF TABLE I IN NUMBER OF PATIENTS

	Active miner, 18 to 65	Retired miner, over 65	Total miner, 18 to 90	Active nonminer, 18 to 65	Retired nonminer, over 65	Total nonminer	Total males
Pneumonia.....	21	21	42	4	13	17	59
Emphysema.....	99	131	230	15	43	58	288
Bronchitis.....	21	27	48	11	9	20	68
Pneumoconiosis.....	22	25	47	0	2	2	49
Asthma.....	19	2	21	3	0	3	24
Tuberculosis.....	3	1	4	1	0	1	5
Carcinoma/Lung.....	8	9	17	5	3	8	25
Bronchiectasis.....	0	2	2	1	1	1	3

TABLE III.—FEMALES

	Wives of miners, 16 to 90	Other females, 16 to 90	Total females, 16 to 90
Pneumonia.....			47
Emphysema.....	89	58	147
Bronchitis.....	36	25	61
Pneumoconiosis.....			
Asthma.....	11	7	18
Tuberculosis.....			2
Carcinoma/Lung.....			4
Bronchiectasis.....			4

TABLE IV.—COMPARISON OF WORKERS (THESE ARE STILL WORKING) (AGE 16 TO 64), MINERS AND NONMINERS WITH DIAGNOSIS OF EMPHYSEMA

Age	Miner	Nonminer
16 to 19.....	1	
20 to 24.....		1
25 to 29.....	2	1
30 to 34.....	3	1
35 to 39.....	9	2
40 to 44.....	17	0
45 to 49.....	15	4
50 to 59.....	27	1
60 to 64.....	25	1
Total.....	99	11

TABLE V.—SAME AS TABLE IV EXCEPT AGE 65 TO 90 COMPARED IN MINER AND NONMINER (RETIRED)

Age	Miner	Nonminer
65 to 69.....	39	12
70 to 74.....	38	11
75 to 79.....	28	11
80 to 84.....	20	4
85 to 89.....	5	5
90 to 94.....	1	0
Total.....	131	43

The CHAIRMAN. Thank you very much.

Mr. KEE. Mr. Chairman, I am indeed delighted at this time to present Mr. George J. Titler, international vice president, United Mine Workers of America.

It is only proper for me to make this observation. Mr. Titler, before he became the international vice president, was president of District 29 of the United Mine Workers, the largest district.

We have been close personal friends for more years, perhaps, than Mr. Titler is willing to admit, and I confess to you, Mr. Chairman, if it hadn't been for Mr. Titler I wouldn't have been elected to Congress.

Mr. Titler?

The CHAIRMAN. We are glad to have you with us and we congratulate you.

STATEMENT OF GEORGE J. TITLER, VICE PRESIDENT, UNITED MINE WORKERS OF AMERICA

Mr. TITLER. Mr. Chairman and members of the committee, my name is George J. Titler. I am the vice president of the United Mine Workers of America.

I appear here today on behalf of the United Mine Workers of America and the coal miners who make up its membership. I also appear here on behalf of the wives and children of coal miners who in the final analysis bear the greatest loss when their husbands and loved ones suffer from the ravages of coal workers' pneumoconiosis.

I have come here today to support H.R. 10499, introduced by Congressman James Kee of West Virginia and Congressman John Saylor of Pennsylvania. In my opinion and in the opinion of the offices of the United Mine Workers of America this legislation would be of definite advantage to the coal miners of America who are now or who will become disabled because of coal workers' pneumoconiosis.

It is interesting to note that the two sponsors of this legislation are from major coal producing States. Congressman Kee represents the largest coal producing district of any Member of Congress. He has long been noted for his espousal of programs which are of benefit to America's coal miners and to their families.

I have personally seen the good that the members of the Kee family have done for the coal miners. And over the years I have been proud to support them for reelection to the Congress of the United States.

Congressman Saylor also has done much to help the men who work underground and to provide security for them and their families. His record in the Congress has done much to encourage support for him among the coal miners of his district and indeed among the coal miners of the United States. We of the UMWA have supported Congressman Saylor for many years. We have done so because he is and has been a friend to our Nation's coal miners and because he has worked vigorously to promote those causes which would redound to the benefit of the miners and their families.

Parenthetically, I might point out that Congressman Saylor has been one of the early critics of the civilian atomic power program. He has led the congressional fight to review and reevaluate the current direction and scope of nuclear power in the civilian field. At first he received little support from either his own colleagues or the public at large. In recent months, however, the wisdom that Congressman Saylor has shown and his foresight in correctly predicting the detrimental effects of nuclear power have brought to him and the program he espouses widespread national support. We congratulate Congressman Saylor on his achievement. He deserves the thanks of every American for his efforts. We hope that he will continue to pursue them in the months and years ahead.

I would like to comment on the problems posed by coal workers' pneumoconiosis in general and the effect that the passage of H.R. 10449 would have in meeting and overcoming these problems.

Coal mining has always been characterized by an excess of death, injury and disease. Coal miners are familiar with the disease known as "miners' asthma," or "miners' con," or "Anthraxilicosis," or as it is now known "coal workers' pneumoconiosis," or "black lung." This disease has caused many coal miners to become disabled. It is a common sight in the coal fields to see old men unable to breathe and finally dying because of the effect of coal dust in their lungs.

Over the years many medical explanations have been given for the shortness of breath and disability of older coal miners. Medical opinion in the United States until very recently adamantly supported the concept that miners asthma was in fact caused by the presence of silica in the lungs. The theory that simple coal dust could also cause disability was long disputed in the U.S., although overwhelming evidence of the existence of the disease was present both here and abroad.

The doctors of the UMWA Welfare and Retirement Fund and the officers of the UMWA tried vigorously to secure a medical recognition of coal workers' pneumoconiosis.

For example I worked very hard to help establish a center on pneumoconiosis in the State of West Virginia. This center is currently functioning.

In recent years the problem of pneumoconiosis has been greatly intensified. The major reason for this is the rapid and almost complete mechanization of America's coal mining industry.

One of the results of such mechanization has been a rapid improvement in the productivity of the American coal miner. In 1950, when coal mining was still basically a hand operation, a U.S. miner produced about 6.7 tons per man-shift. In 1969 this output had climbed to almost 20 tons per man-shift. In the period between 1950 and 1969 productivity has been almost consistently upward.

These figures are taken from the U.S. Bureau of Mines. They are national figures representing a statistical average of all underground and surface mines in the United States. As such, they are not truly reflective of what has happened in the more productive sectors of the bituminous coal industry.

A modern U.S. underground mine can produce approximately 30 or more tons per man-shift. Some mines are now producing 50 tons per man. New technology currently under test can cause this figure to increase to 100 to 200 tons per man.

Between 1950 and 1969 the U.S. bituminous coal industry underwent a virtual revolution in productive technology. New machinery and new mining techniques were introduced at a rapid pace. The continuous miner, which was virtually unknown in the early postwar period, grew in importance until today it is responsible for more than 50 percent of the underground production.

This mechanization enabled the coal industry to meet stringent market demands. It permitted coal to maintain a stable price structure in a period characterized by intense inflationary pressures.

However, the rapid mechanization of the mining industry markedly increased the dust level in the U.S. underground mines. With this

increase came increased dust exposure for the men and the probability that these men would ultimately contract coal workers' pneumoconiosis. Unfortunately, this is what has happened. It has been estimated that more than 100,000 coal miners in the United States today suffer from coal workers' pneumoconiosis. It is also estimated by experts employed by the UMWA or by the UMWA welfare and retirement fund that approximately 50,000 men are disabled to one degree or another because of coal workers' pneumoconiosis.

Coal workers' pneumoconiosis is, in my opinion, the single most important problem in the occupational health and safety field. No other industry, or no other class of workers, suffer to the same degree from occupational health problems.

Moreover, it is increasingly apparent that unless prompt and immediate steps are taken the incidence of coal workers' pneumoconiosis will become even greater in the years ahead.

Happily, the Congress has acted in this matter. Within the last week the House of Representatives enacted a stringent bill regulating the amount of dust to which a miner can be exposed. The Senate has also passed legislation in this regard. The final bill should contain stringent restrictions on dust exposure.

However, the passage of preventative laws will not care for the victims of coal workers' pneumoconiosis who are now disabled because of the disease. Simple justice dictates that these men be provided for, both by effective Federal and State compensation laws and through the medium of social security as set forth in H.R. 10499.

Before proceeding to comment on the legislation itself, I want to impress upon the committee one important point. Coal workers' pneumoconiosis is no longer a disease for the old. We are beginning to see increasing numbers of younger men who are disabled because of coal workers' pneumoconiosis. We are beginning now to witness the tragic spectacle of men in their late thirties and early forties who are no longer able to function because of the heavy burden of dust which they carry in their lungs. We are also witnessing the rising incidence of disease and illness related to pneumoconiosis. Such things as right-sided heart enlargement, lung function impairment, and so forth, are becoming increasingly common among the mining population of our Nation.

Therefore, we support the bill introduced by Congressmen Kee and Saylor. We also support efforts to enact Federal compensation statutes as well as effective compensation laws at the State levels.

I would like to make several comments on the bill, H.R. 10499. First, we support and urge the adoption of the language in the bill which defines pneumoconiosis as—

A disease of the lung resulting from the inhalation over a prolonged period of minute particles of coal dust diagnosed by generally acceptable clinical techniques and accompanied by shortages of breath on moderate exertion.

This definition and method of diagnosis will go far to removing the inequities currently in State compensation statutes and under the Social Security Act. It broadens the definition of disability and the definition of pneumoconiosis to embrace the disease as it currently exists. It permits a man to receive social security disability without the application of unduly rigid standards which currently exclude all but a handful of coal miners.

Medical evidence supports the definition and the methods of diagnosis contained in the language I have just read. It will, if adopted, reflect the updating of diagnostic techniques and the latest medical evidence concerning the disease coal workers' pneumoconiosis. In our opinion, the definition and diagnosis of the disease are of crucial importance. For, we have found prohibited little good to recognize that coal workers' pneumoconiosis is a disease if its definition and diagnosis are so rigidly circumscribed that few men can qualify for benefits.

We also subscribe to the language in the bill which ties the disability to the ability of the individual to perform a job requiring skills or abilities comparable to those in which he has previously engaged. To quote the proposed statute:

* * * inability by reason of such pneumoconiosis to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he has previously engaged with some regularity over a substantial period of time.

All too often those regulating the disbursements of benefits have refused to grant benefits if a man could secure any type of job. Unfortunately, the ability of a man to secure "light work" and his ability to perform "light work" are not the same. It is one thing to say that a man can be a service station attendant. It is quite something else for a miner 45, 50 or 55, or even 60 to secure a job in that category.

Within the last several months the UMWA has drafted legislation which we hope to have introduced in the next session of the West Virginia Legislature. In that legislation the UMWA ties disability to the standard contained in the Kee-Saylor bill, that is, the ability to perform his usual occupation. We believe that this is the only true test that can be made.

Finally, we agree and concur in the language of H.R. 10499 which would provide medical benefits and disability insurance to coal miners suffering from coal workers' pneumoconiosis without regard to age. Such extension represents a meaningful revision of the Social Security Act. It represents a recognition that men who are disabled because of their occupation should be cared for whatever their age. It is certainly in line with the congressional intent and the moral objectives of the Social Security Act to provide such benefits. Thus, any disability, whether it be aged-related or work-related, should be cared for. We congratulate and we support Representatives Kee and Saylor in this effort they have made. We urge the House to pass H.R. 10499.

Mr. Chairman, for most of my life I have worked in coal mining or I have served coal miners. Coal miners traditionally have contributed much to the citizens of the United States and to the well-being of our Nation. In making this contribution they have endured a terrific toll in illness, in injury and in death. We ask on their behalf for congressional legislation to prevent the incidence of disease, injury and death and to care for those unfortunate victims for whom preventive measures are too late. The Congress in recent days has responded affirmatively to some of our requests. We hope they will respond affirmatively in the case of H.R. 10499. We ask this not because we seek Government handouts or because we want to be cared for by the general public. Rather, we feel our request is justified by the contributions they daily make as they produce the energy which America so desperately needs and which has made our country pre-eminent among the nations of the world.

Thank you for your attention.

The CHAIRMAN. Thank you.

Mr. KEE. Mr. Chairman, due to the redistricting in West Virginia which took place last year, I was assigned by the legislature Raleigh County, which is the largest county in my congressional district, so I am happy at this time to present Mr. Odell Gwynn. He is president, Chapter 5, of the Disabled Miners and Widows Association of Beckley, W. Va., which is the county seat of my new county, Raleigh County.

The CHAIRMAN. We are glad to have you with us, and you are recognized.

STATEMENT OF ODELL GWYNN, DISABLED MINERS AND WIDOWS ASSOCIATION

Mr. GWYNN. Mr. Chairman and members of the House committee, I am Odell Gwynn, of Beckley, W. Va., Raleigh County.

As Congressman Kee stated, I represent the Disabled Miners and Widows Association of over 4,000 widows and miners and I would like to present to you this morning my statement for your consideration.

We are in favor and support the bill H.R. 14099 to make disability insurance benefits and the disability freeze more readily available to coal miners and other individuals suffering from pneumoconiosis, and to amend title II and XVIII of such act to make health insurance benefits available without regard to age to all individuals receiving cash benefits based on disability.

Coal mining is the most hazardous occupation of any industry. There are many miners that become maimed at a young age for life by mining machinery. There are many that become disabled by contracting what coal miners call miners knee. This is something that comes on your knee, sometimes it is about the size of a cantaloupe ball. This comes from crawling around on your knees on the bottom of the mine floor and many times those men with those knees have to be lanced or operated on. I have known two men who have stiff knees after surgery on their knees and some are young men.

Some young men becomes disabled with a rheumatic condition, arthritis and what have you. These people are not old enough to be eligible for medicare, but all of these people are in the need of medical aid, but unable to secure any. We would like to see the rules of social security changed so thereby these people may be covered. Medicare is needed now for our people, not later, but at the present time. Our young disabled people need medical aid coverage. We think that regardless of age when anyone becomes disabled that they be entitled to medicare benefits.

I have worked in the mines 27 years and I know the conditions of the coal mines and the widows and their needs, and we are very happy that you took time out to hear us. We thank you.

The CHAIRMAN. Thank you.

Mr. Kee?

Mr. KEE. Mr. Chairman, before introducing the next witness in my statement I failed to mention one very important factor. As a member of the Mines and Mining Subcommittee of the Interior Committee, it was my privilege to preside over hearings which have been printed

that were held on April 15 of this year. Of course April 15 is income tax day. I would remember it. And, also, it was my birthday. We brought out during those hearings on April 15 from the leading experts throughout the United States that, No. 1, coal provides 50 percent of the energy demands of the United States today. It is projected by the experts that during the on-coming 14 years the energy demands of the United States will increase 400 percent.

I want to see that our coal people have an opportunity to share in their portion of this market that we know is coming.

I might add this: I took a tour as a member of the Subcommittee on Flood Control all through the Tennessee Valley Authority. We brought out very definitely at that point that of the power produced by the TVA 80 percent of their power is provided by coal which comes from not only my congressional district, the Fifth District of West Virginia, but Congressman Carl Perkins' district, who adjoins me on the Kentucky side, as well as Congressman Wampler's district on the Virginia side.

I just wanted to make that point, Mr. Chairman, of really the urgency and the importance of coal to supplying the energy demands and to the basic future of America.

Mr. Chairman, for 27 years my mother and father had the privilege of representing Greenbrier County. Well, we had a census in 1960 and 1961. The legislature in its wisdom took Greenbrier County away from us, so I regret the loss but they are more ably represented because they have the privilege of being in the district of Congressman Harley Staggers, chairman of the Interstate and Foreign Commerce Committee, so while it was my personal loss, it was a gain for the residents of Greenbrier County.

I am now happy to present Mr. Charles Omechinski. He is president of Chapter 13 of the Disabled Miners and Widows Association at Quinwood, W. Va., which is located in Greenbrier County.

The CHAIRMAN. We are pleased to have you with us, and you are recognized.

STATEMENT OF CHARLES OMECHINSKI, QUINWOOD, W. VA., PRESIDENT, CHAPTER 13, DISABLED MINERS AND WIDOWS ASSOCIATION

Mr. OMECHINSKI. Mr. Chairman, my name is Charles Omechinski, of Quinwood, W. Va., and I am happy to be here before the Ways and Means Committee and U.S. House of Representatives.

I want to say I am glad and proud to have been asked to appear here before you and to thank you, and especially Congressman James Kee, to be able to appear on the behalf of 1.4 million disabled people on social security, to ask for medicare for all disabled under the age of 65. As the disabled man or widow and their children need this medicare bill, as most cannot afford insurance and the disabled cannot get it. If he is a veteran, he has hospitalization for himself only. I have talked about this medicare with Congressman James Kee and Congressman Ken Hechler, who both have stated that the disabled should have medicare to help their families. We are in complete agreement that something should be done for the people under 65.

I see and know the people I am talking about and I know this is just a very few. For instance, Benton Conard of Nettie, W. Va., age 49. His wife and eight children, total of 10 in family. They have a social security of \$339 a month. Mr. Conard needs medical care twice a week, but will go only once a week unless he gets so bad he has to make the second trip because he cannot afford the medical bill, as he has a baby, which was born with too many arteries to its heart—enlarged heart—and was considered a blue baby, because his coloring is too blue. He is 4 years olds, weighs 30 pounds and has never taken his first step. He has to have constant care. Also a daughter who needs medical care. His wife's heart is bad. Their medical bills are from \$150 to \$180 a month. All but two of their children are in school.

Golden Mullins of Cowen, W. Va., age 38, has lost both legs up so far that he cannot use artificial legs. He is father of six children. He is on social security, but doesn't have hospitalization for his family.

Reverend Basic McDaniel, age 43, of Meadow Bridge is disabled, has a wife who needs a serious operation and has for 1 year. The doctors say she will not be any better until she is operated on. They have five children at home, four of these are under 18 years of age. Three are in school, and the baby of 4 has a bronchial condition. This man's income is approximately \$200 a month on social security. He was in the hospital 3 days and the cost was over \$125 and now the hospital has threatened to sue him for the sum of \$68. The doctors told this man not to bend over as he had a slipped disc.

Houston Richardson, Quinwood, W. Va., about 50 years of age, with a wife and two children. He needs medical attention, but most of the time will not go unless he really has to, as he cannot afford it.

James Morillo, Rainelle, about 40 years of age, with wife and children—no hospitalization.

Darris McClung, Richwood, age in his thirties, has wife and family.

Dennis McClung, Richwood, in his thirties, disabled, wife and family.

E. E. Cody of Fayetteville. Has wife and children. Disabled. Draws social security, no hospitalization.

Daily Hart of Replete, under the age of 65. Totally disabled. Has a wife.

Howard Gwinn of Meadow Bridge. Has a wife. Totally disabled.

Colon Pitsenbarger, Rainelle. Totally disabled. No hospitalization.

These are a few of the 1.4 million and I could name others, who are in the same shape. We ask that you consider these people on social security and are all under the age of 65. I feel that any disabled man with a family, or widow, if she has children or does not, should have social security Medicare, as none of these disabled can get any kind of insurance, and most cannot afford it, because cost of living and insurance is so high.

That is my statement, sir.

The CHAIRMAN. We thank you, sir, for your statement.

Mr. KEE. Mr. Chairman, the last witness is Mrs. Charles Omechinski. She is secretary-treasurer of Chapter 13 of the Disabled Miners and Widows Association, and while Mrs. Omechinski resides in Greenbrier County, which is no longer in the Fifth Congressional District of W. Va., she is also very active in two other major coal producing counties that are in the Fifth Congressional District of W. Va., and is a

very fine lady, has done considerable research, has had, on a first-hand basis, contact with the widows who have suffered because of the disability, the lack of any possible earning power of their husbands, and children. So, at this time, sir, I am very happy to present Mrs. Charles Omechinski.

The CHAIRMAN. We are pleased to have you with us.

**STATEMENT OF MRS. CHARLES OMECHINSKI, QUINWOOD, W. VA.,
SECRETARY-TREASURER, CHAPTER 13, DISABLED MINERS AND
WIDOWS ASSOCIATION**

Mrs. OMECHINSKI. Mr. Chairman, and fellow Congressmen, I would like to thank each of you for letting us appear here with you and the Honorable James Kee from our home State of W. Va., who has worked hard and did a lot for the miners in our area, and also Congressman Saylor on this House bill 10499.

I am also very happy and glad to see that someone has taken an interest in what is happening to the 25 million people or more on social security; men with wives and children, or widows raising children. I am very happy that you men in our Congresses, and I know some of you do not come from mining areas, are interested in seeing that people on disability could have medicare, regardless of age and will not have to wait until the age of 65. I have talked this matter over with the Honorable Congressman Kee and the Honorable Ken Hechler many times and I feel we are all in agreement that these people should be able to get medicare.

I am the secretary-treasurer of the largest chapter of the Association of Disabled Miners and Widows, Inc. I visit these people and talk to them, not only members of the association, but all of the people and listen to their hardships and problems, and I try to give them all the help I can. I understand these people, and I know their hardships because we had them in our own home.

My husband became disabled at the age of 43. He had to have a lung biopsy and one lobe taken out. The doctors, in February, said that he has 70 percent pneumoconiosis and 10 percent silicosis, that his lungs are completely covered by dust. He has been unable to work since then and will never be able to work as this has been a hard thing on his heart and he has suffered from seven heart attacks and my family and I feel very lucky that we have him with us.

We had three small children to take care of and keep in school. My 11-year-old daughter at that time had and was being treated for rheumatic fever, hepatitis, and scarlet fever. She went to the hospital every day for 1 year, as the doctor and I felt I could take care of her at home. When this happened she was 6 years of age. She was never allowed to be out and play with other children until the age of 13 or 14. I think it was 14. My husband, Charles Omechinski, had to have five different kinds of medicine each day. The doctors say he has to have this medicine to live. Now I am paying off three hospital bills, which total over \$2,000, and just finished one bill. I have an insurance policy that is so high that most people can't afford to buy insurance, a lot cannot pass the physical to get it.

Mr. William Simpson of Elkins, W. Va., is disabled and has a wife who is under a doctor's care. The doctors have Mr. Simpson on a special diet of high protein. He draws social security but no hospitalization.

Mr. Lawrence Bennett of Minden, W. Va., has to have oxygen 7 days a week, 24 hours a day. His wife cannot leave him to go to work, they have one son. We wrote to the President, the Governor, to Congressmen and Senators, the State welfare and department here in Washington to try to help this man. It was always referred back to our State welfare. They said they would give him oxygen if he would go to a nursing home, why should a man have to leave home if he is able to stay there with his family to have oxygen and care. He lives on social security and his wife is willing to take care of her husband. They live in a house free of rent if they take care of it and the boy helps by working for the neighbors. This man isn't 65 years old and without oxygen will never live to see that age. He wants to live as much as anyone, but he also sees the hardships he puts on his family.

Mrs. Lucille Boggs of Camden on Gauley, has to have from 7 to 10 tanks of oxygen to be able to live. We wrote to everyone whom we thought could help her and it was always referred back to the State welfare department. They said they could not help her because of the amount of social security. No one took the time to look and see how much it cost her for her oxygen to live. Her husband and children had to watch her, as she would take the oxygen off because she saw what was happening to her husband. In January, Bulue Boggs came to us with tears in his eyes. He said when he went to get his social security check, there was a miner's pension check for 3 months. This man lived to draw that check in February, when they found him dead of a heart attack. He had worn himself out and the heart couldn't take any more. She will have a hospital card for 2 years, then what is going to happen to her? Without help, our association chapters helped as much as they could and can. But all of these people are disabled miners and widows.

Mrs. Holcomb came to me this month, saying she has an \$8,000 hospital bill to pay off. She is over 50 years of age and she works hard to try to keep up payments on this bill as the hospital says they will sue her. She would lose her home, the one thing her husband left her. She looked at me and said, "I will never live to pay it off, but I am trying." She is not old enough to draw social security and can't afford insurance.

Thomas Fitzwater of Hinton, W. Va., draws social security but cannot get insurance for him or his wife, as they both are in a serious condition. He has had a heart attack and a very bad heart. His wife is very ill and her parents say they expect every day to hear she is dead. They help, when they can, but her father is on social security and is old enough to have medicare.

Mrs. Verna May Jackson, Baisden, W. Va., has two children. She draws social security and if she has hospitalization she has to pay out what income she gets to live and send her children to school.

Posey Stewart, Oceana, W. Va., draws social security and she can't get hospitalization.

Howard Linville of Peytona, W. Va., has a large family and lives on social security—no medical care.

Clarence Keener of Quinwood, W. Va., has a family, six children. He and his wife draw social security.

Laura Tucker, age 59, is crippled in one leg—her husband was disabled up until death. William Tucker, Craigsville, was in a mine explosion, draws social security—no hospitalization.

Mrs. Gray Burkett of Bluefield, W. Va., widow, no hospitalization.

Mrs. William Burcell of Bluefield, W. Va., has a daughter 30 years old, who has to have constant care by her family.

Louie Omechinski, father of two children and wife, whom his wife and one child has a dead brain cell, needs care. They have social security but no insurance.

I had a lady come to me at Bluewell in Mercer County. She has a \$7,000 hospital bill she is paying off and another hospital is threatening to sue her for \$3,000. This is what is happening to our people, not only the miners. It is everyone in the United States who is on social security.

These are just a few of the 28 million disabled and widows who have no medicare, some of these women have to work as they have no children under the age of 18, or up to 24 years of age in school. Insurance companies are so high that they can't afford the payments. The children cannot have insurance unless one of the parents is on the policy and most can't pass for insurance. If you have to go to a hospital, before the doctor sees you, he will ask if you can pay at least \$100 before being admitted. Since hospital prices have risen, I tried to get my own insurance raised just for room and board. The company refused. But I pay for a policy that was supposed to have complete coverage, but they don't want to raise the room for rent. My daughter was in a hospital at Beckley, in a ward with 10 beds which cost \$27 a day. After surgery, she was in a two bed ward which was \$38 a day. These beds were in this hospital I know of in 1939, as I was a patient at that time. I spent 10 days in a hospital in Maryland and the hospital bill was over a thousand. My insurance paid \$598. This is what these people are up against. If they are disabled, why should they have to wait until the age of 65 to get medicare? They can't get insurance or no State assistance. The people on State welfare have complete coverage by the doctor, hospital, teeth pulled, glasses, and their medicine.

These people cannot get any help from the State because of their social security, less than \$80 a month and can get no State assistance. These disabled widows and their children need medicare and bad. We ask that you take all of this into consideration and pray that you will see and find a way to help these people by giving medicare. We ask not only for the ones we have mentioned, but the 25 million people. We live in the richest country in the world and we see this happening to our own people. These men worked hard and most fought for this country to keep it a free one. If the man is a veteran, he is the only one in his family that can go into the hospital for veterans. What about the children who are usually in need of medical care? A mother who has raised a family, she also needs medical care. We ask again for a bill for medicare for all of these people. You have our prayers and most of all we pray for help for all of these people. They don't want charity, as most of these worked until they became unable to work.

Thank you for your time in listening to me.

My prayers to all of you.

The CHAIRMAN. We thank you, Mr. Kee, and we appreciate your bringing this matter to our attention and also bringing with you these very fine witnesses from your State of West Virginia.

Let me understand, if I may now, the purport of the statments all of you have made. Are you suggesting that we include in the medicare program people under 65 who are already drawing disability cash payments under social security? Is that what you are suggesting?

Mr. KEE. Yes, Mr. Chairman. I am suggesting, and I would hope in the wisdom of your committee that all of those that are drawing social security disability, regardless of age, when they need to be hospitalized to save their lives or to prolong their lives, be included the same as the aged under the medicare program.

The CHAIRMAN. I am all for the suggestion. I have said so on many occasions, because I know these people by the very nature of their relationship to social security are certainly in as great a need of medical assistance as some who are over 65, so I say I am all with you on this and I have said so publicly many times.

Anything further?

Mr. Ullman?

Mr. ULLMAN. I want to congratulate our colleague for marshalling such a powerful argument here for his position and for confining his testimony to that position. I couldn't agree more with the chairman. I can't let the occasion pass without referring to both your father and mother, who preceded you and who fought the battle for the miners for so many years, and I hope you will convey my regards to your mother when you see her.

Mr. KEE. Thank you very much.

The CHAIRMAN. Any further comments?

If not, we again thank all of you for coming to the committee.

Mr. KEE. Mr. Chairman, in conclusion, if I just may make one observation, it is difficult for me to find words to adequately express to you the gratitude from the very bottom of my heart, Mr. Chairman, for granting us this opportunity to come before your committee on this matter of such urgency, of such vital importance, to so many people.

In conclusion, Mr. Chairman, please, in your compassion when you mark up the bill, I hope that you will take as much of this as you can in the wisdom of your committee, sir.

The CHAIRMAN. Thank you again, Mr. Kee.

We thank all of you. We appreciate your coming.

Mr. KEE. Thank you very much. Thank you.

Mrs. OMECHINSKI. Thank you.

(The following letter was received by the committee:)

BECKLEY APPALACHIAN REGIONAL HOSPITAL,
APPALACHIAN REGIONAL HOSPITALS,
Beckley, W. Va., November 3, 1969.

Representative WILBUR MILLS,
Chairman, House Ways and Means Committee,
Washington, D.C.

DEAR CONGRESSMAN MILLS: I understand that hearings are to begin in your committee regarding certain aspects of the Social Security Act. I respectfully request that this letter be entered as testimony into the record of the hearings.

I am a certified internist and pulmonary disease specialist. For the past seven years I have performed detailed physiologic evaluation of respiratory function and work capacity in subjects with respiratory diseases in the Cardiopulmonary

Laboratory of the Appalachian Regional Hospital in Beckley, West Virginia. While the majority of my patients have been bituminous coal miners, of which more than 4,000 have been evaluated, my remarks are not limited exclusively to miners.

In my capacity I have very often observed the frustration and despair of the disabled worker who is repeatedly denied benefits under the Social Security Administration. In most such cases, application for disability benefits is the last resort. This is particularly true for coal miners of this region. These men continue working in the coal mines for long periods after they become aware of bothersome shortness of breath and other symptoms. In some cases men with almost unbelievably disabling lung disease are encountered still working.

There are a number of factors responsible for these conditions. Non-mining employment is scarce and generally undesirable in this region. In the absence of periodic health examinations, a miner is generally too old and too infirm to compete on the labor market by the time he realizes his health is failing. His strong sense of obligation to his family's well-being leads him to continue mining instead of accepting the uncertain and infrequent alternatives. All too often, however, the miner is unable to continue his employment beyond the period of heavy financial obligation. He is denied a pension until age 55, regardless of his disability. Workman's compensation is, at present, most often inadequate, and often very difficult to obtain. Even public welfare assistance is provided grudgingly if provided at all. In spite of current beneficial legislation for measures to reduce health hazards and provide needed compensation for coal miners, there remain many who will benefit from neither.

The present rigid criteria for disability benefits under the Social Security Act are unrealistic and inhuman. It is by no means rare for an individual to die while attempting to obtain sufficient medical evidence of disability to qualify for social security benefits. To demand that a worker endure pain or constant fatigue or distressing shortness of breath, in order to survive, is to demand performance beyond human endurance. Denial of benefits rarely achieves a goal of re-employment, but merely swells the rolls of those receiving meager welfare doles.

The setting of arbitrary values for certain parameters of respiratory or other functions implies a validity, which is in fact, non-existent. None of these values, regardless of its precision, measures pain, shortness of breath or fatigue, for example. The latter are the kinds of factors which limit performance in the human. There is great fallacy in basing judgments on the numerical values generated in many work-evaluation studies, without proper consideration for the individual human involved.

The existence within the economy of a job or jobs which an applicant might be able to perform is an unrealistic basis on which to deny benefits on at least two counts. First, there is no method of accurately determining an individual's capability to perform a given job. Second, too many of those specific examples of given jobs are sufficiently uncommon to be considered as anomalies. Others even appear to have been created out of the compassion of an employer for an aging or needy worker.

There is a great need for a compassionate re-appraisal of the disability requirements under the Social Security Act. It is my hope, and that of many others, that the committee will see fit to modify these criteria. This humanitarian action could justly benefit many whose previous productivity has added to this nation's economy.

Sincerely,

D. L. RASMUSSEN, M.D.

BECKLEY, W. VA.

Chairman WILBUR MILLS,
Chairman, House Ways and Means Committee,
House of Representatives,
Washington, D.C.:

My letter addressed to you dated November 3, 1969, concerning the Social Security Act was intended specifically to support HR 10499 sponsored by Representative James Kee, Democrat from West Virginia.

DONALD L. RASMUSSEN M.D.,
Appalachian Regional Hospital.

The CHAIRMAN. We have with us today Hon. Patsy T. Mink from the State of Hawaii. Mrs. Mink, we appreciate your coming to the committee and you may proceed.

**STATEMENT OF HON. PATSY T. MINK, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF HAWAII**

Mrs. MINK. Mr. Chairman and distinguished members of the committee, I appreciate this opportunity to present my views on the need for an immediate increase in social security benefits.

In summary I propose the following: (1) an increase in social security benefits in the range of 50 percent; (2) an immediate increase in the minimum primary benefit to \$100 with subsequent increases to \$120 a month by January 1, 1972; (3) removal of discrimination against women in the social security program; (4) extension of the tax base to all taxable income; (5) provision of disability insurance benefits for the blind as sought by my bill, H.R. 12273; other charges along the lines of H.R. 14430, sponsored by Congressman Gilbert.

Our elderly and retired citizens have been severely hit by the inflation of recent months and thousands can no longer afford adequate food, clothing, and shelter, much less the comforts the rest of us take for granted. Workers who counted on social security to provide for them during retirement are living in poverty by the Government's own criteria.

We must act now to remove the specter of malnutrition, disease, and misery facing our older citizens by enacting a social security bill that will complement the monumental tax reform bill, unemployment compensation bill, and other landmark legislation initiated by this committee this year.

Our goal should be maximum benefits with least taxation, or equitable treatment of contributors and beneficiaries. Currently there is an imbalance against those benefiting from social security. Due largely to increases in worker income, we could increase OASDI benefits by 17½ percent right now with no increase in social security payments. There is, however, a 50-percent inadequacy in medical insurance fund income which should be reduced by removing abuses of the medicare and medicaid programs which have increased medical costs enormously.

But differently, OASDI needs only \$27.2 billion to maintain existing benefits this year rather than the actual \$32 billion income. Medical insurance plan income of \$6.9 billion is needed rather than the actual \$4.6 billion. In total the social security system needs only \$34.1 billion this year instead of \$36.6 billion being collected, to maintain long-range actuarial integrity. The difference, \$2.5 billion, is the amount by which benefits could be increased immediately with no change in financing.

The administration has recommended increasing the taxable wage base to \$9,000 from the existing \$7,800. Either figure would continue the regressive nature of social security financing. Under this arrangement the average worker pays social security taxes on all or nearly all of his income, while wealthy individuals escape taxation altogether on all income above \$7,800. Moreover, upper income brackets take advantage of other loopholes through capital gains, dividends, corporate income, and other privileged income.

Thus, if we enact the administration proposal the wealthy will continue to escape paying their fair share of the cost of the social security system while still enjoying benefits equal to those paid for by the workingman. This is an enormous tax loophole such as those

we have tried to correct by adoption of tax reform. We should remove this inequity by expanding the tax base to include at least all income subject to social security taxes.

According to the Social Security Administration, some \$372.3 billion in wages and \$27.4 billion in self employment net earnings is being taxed for social security purposes during the present tax year, 1969. The total is about \$400 billion subject to tax within the current limit of \$7,800. Simply by expanding the base we could tax \$451.8 billion for a total of about \$500 billion. We could thereby add \$100 billion to the taxable base immediately by removing this loophole for the wealthy.

The combined employer-employee contribution rate for next year is scheduled to be 9.6 percent. By expanding the wage base we could have an additional sum of about \$9.6 billion in increased income which could be used either for a large increase in benefits, or a large decrease in payments or a combination of both.

Since total personal income in the national income account is expected to be about \$747.5 billion this year, there are prospects for inclusion of other income in the base subject to social security taxes. Overall, reform of the financing system to eliminate its regressive features should allow meaningful increases in benefits, without the need for general revenue funds.

I firmly believe this change would result in a reduction in taxes on the great majority of working people. It would also expand employment. Because of the current limitations of the tax to the first \$7,800 of earned income, employers have a strong incentive not to hire new workers. Instead, they attempt to get more work out of those employees they already have.

Employers would prefer to pay one person \$15,600 in income and pay their share of social security taxes on only \$7,800, than to hire two workers at \$7,800 each and pay taxes on \$15,600. The general result is resistance to the employment of new workers. We find increased overtime and more stringent workload demands on existing employees instead. Removal of the wage base limitation would remove this incentive to unemployment and at the same time continue to allow workers to have overtime in cases where they and the employers desire it.

In addition, the higher benefits made possible by this change would remove the necessity for many social security beneficiaries to supplement their income. You have before you many proposals to increase the amount of income an ostensibly retired person could earn and still receive social security benefits. I approve of a retired person being able to supplement his income if he chooses, but we should remove the economic necessity of this. Social security should provide adequate benefits so that a working person could truly retire and enjoy his senior years without the penalty of poverty or the need to continue working full or part time. This would also tend to make more jobs available to younger workers now unemployed or underemployed.

Since the committee has received extensive testimony on most of the other subjects I mentioned at the opening of my remarks, I would like to limit my remaining comments to benefits for the blind and providing equal social security benefits for women.

Under my bill, H.R. 12273, persons who meet the definition of "industrial" blindness would be considered disabled regardless of their capacity to work, and could receive social security disability insurance benefits for any month in which they do not engage in substantial gainful activity. The bill would eliminate the alternative definition of disability that now applies to blind workers aged 55 and over, requiring inability to do previous work or any similar work. Disability benefits would be payable after age 65 to blind workers who have six quarters of coverage even though they are not insured for retirement benefit purposes. I strongly commend the purposes of this legislation to the committee in the hope that the forthcoming legislation in this field will incorporate such a provision for the blind.

The existing social security system renders a great inequity to women. They work and contribute on an equal basis with men, but because they may be wives, women do not receive equal benefits. It is mandatory that we amend the law to provide equity for working men and women by recognizing the working wife's contribution. The law is based on the rigid premise that a woman's place is in the home, yet increasing numbers of women are working and therefore suffering from this inequity.

Specifically, there must be benefits for the married, working woman based on her contribution; and married couples must be allowed to pool their income for the purpose of computing social security benefits. This is the purpose of legislation which I first sponsored in 1966. Husbands, widowers, and children of working women are also entitled to the same benefits which wives, widows, and children of men workers can now receive. Another inequity is the fact that if a husband becomes mentally ill and is committed, he must prove dependency on his wife, in order for benefits to be paid in cases where the wife works. If the wife does not work, she can receive benefits.

I fail to see the logic of these laws which penalize working women merely on the basis of sex. This form of discrimination should have been abolished long ago, yet it continues to linger on the statute books as an archaic remnant from the time when women did not have equal rights before the law.

The social security system pattern of discrimination against working women should be eliminated, but not at the expense of the nonworking wife. Why should a retired couple get less in total monthly benefits if both worked, than a couple receiving benefits based on the same total earnings where only the husband works? This is not only discriminatory but illogical, arbitrary, unfair and contrary to national policy.

If only the husband has worked and had average earnings of \$650 a month—\$7,800 a year—the benefits paid to the couple at age 65 would be \$323 (\$218 to the husband and \$105 to the wife). On the other hand, if the husband and wife each had average earnings of \$325 a month, or \$3,900 each a year—for combined annual earnings of \$7,800—their benefits will be lower, \$134.30 each or a total of only \$268.60. This penalty of \$54.40 a month or \$652.80 a year is grossly unjust at a time when women comprise 37 percent of our Nation's work force, more than half of whom are married.

Under the present system a wife who has never worked under social security may receive as much under her wife's benefits as another woman who had worked and paid contributions. This is another disincentive to employment built into the system. For example, such a non-

working wife would receive \$105 as a wife's benefit if her husband received the maximum of \$650 monthly; on the other hand, if the same wife worked and paid contributions on average monthly earnings of \$120, she would be entitled at age 65 to a benefit of \$81.10, plus an additional wife's benefit of \$23.90, for a total of \$105—the same as if she had never worked at all. This is an incredible way to manage what is primarily a work-related insurance system.

On a dollar-for-dollar comparison, the working wife is receiving a poor return for her contribution. This is true at a time when married women outnumber single women in the work force by two to one. The solution is to provide a working woman's benefit on top of, instead of in lieu of, a wife's benefit. This would recognize her financial contribution to the system and at the same time be consistent with the principle of equity between men and women.

As I have said, current policy discriminates between treatment of husbands and widowers. At present husbands and widowers only receive benefits from their working wives if dependent, yet a wife receives spouse's benefits whether dependent or not. This dependency requirement for entitlement to husbands or widower's benefits should be eliminated in accordance with the general equity which we should strive to achieve.

In light of this, I should mention also that no provision is made for payments to male widowers with surviving children, despite the fact that the considerations which require payment in the case of widows seem to apply also to men. This should also be remedied by authorization of father's as well as mother's insurance benefits.

I have touched only some of the matters which the committee must consider in seeking new amendments to the social security law. In brief, I feel that significant increases for all social security recipients are necessary immediately including benefits paid under our aid to dependent children program. The system's inequities with regard to different benefits for men and women should also be removed, and more benefits should be paid to the blind.

The increased benefits, which would remove thousands of our elderly citizens from poverty and help reduce unemployment, should be financed through expansion of the social security tax base to all income with a concomitant reduction in the tax rate.

I am confident that the committee will approve significant legislation in this field, just as it has acted so beneficially on other matters in the current session.

The CHAIRMAN. Thank you for your statement, Mrs. Mink. Are there any questions. Again, the committee thanks you for coming.

Congressman Lester L. Wolff of New York is our next witness today. Please come forward and proceed, sir.

STATEMENT OF HON. LESTER L. WOLFF, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. WOLFF. Mr. Chairman, I would like to begin by thanking you and the distinguished committee for affording me the opportunity to submit testimony on a matter which has concerned me since I entered Congress nearly 5 years ago.

With each passing year, I have seen an increasing number of elderly citizens unable to meet the cost of living on their fixed incomes. As costs and prices have continued to spiral, their situation has grown progressively worse. Much of this, I feel, is the result of a failure to provide a social security system with a safety valve to meet fiscal pressures.

As you know, earlier this session I introduced a bill which I believe would correct this. My bill, H.R. 9808, called for an immediate increase in social security benefits to be accompanied by yearly automatic adjustments to meet the cost of living. In this way, Mr. Chairman, I feel we would insure that our senior citizens receive adequate funds upon which they could live.

In addition, I have joined with a considerable number of my colleagues in requesting that the immediate increase in benefits be 15 percent. This is imperative if we are to succeed in efforts to update our social security system.

Mr. Chairman, I was gratified to see that the administration has come to endorse my original proposal for automatic annual adjustments to meet cost-of-living increases. However, I was comparably dismayed that the administration has only requested an immediate increase of 10 percent. Although admittedly, any increase is beneficial, I still maintain that unless we increase benefits by 15 percent, we will not be totally meeting the real economic problem.

Our senior citizens are finding it progressively more difficult to meet living expenses on their present fixed income. It is not all too infrequent for me, and I am sure many of my colleagues, to receive letters from senior citizens who have found it necessary to take on part-time jobs in order to make ends meet.

Unless a sufficient immediate increase is adopted, and we plan for annual adjustments to meet the cost of living, we will only be delaying subsequent confrontation with this same problem. And I assure you gentlemen, each time we delay action, or attempt to cut fiscal corners where essential increases are required, we will increase the possibility that this situation will grow so great in scope that we will find it extremely difficult to tackle at some later date.

By instituting realistic measures however, we will provide our senior citizens with the just compensation which they were promised when social security was originally established. Moreover, Mr. Chairman, we will be insuring that Congress will not have to face a time-consuming, emotional and frustrating confrontation with the same matter in the near future.

I think that we all agree this is a matter of great urgency. And I trust that we will treat it not as something to approach timidly, but as a situation in which we can demonstrate congressional concern for the future of our senior citizens.

The CHAIRMAN. Thank you for your statement, Mr. Wolff.
Mayor Maier?

The Honorable Henry W. Maier is the mayor of the city of Milwaukee, and is appearing in behalf of the U.S. Conference of Mayors.

We appreciate very much, Mr. Maier, your coming to the committee, and we are glad to recognize you, sir.

Mr. Byrnes?

Mr. BYRNES. I would like to welcome the mayor of our great city of Milwaukee. He and I have known each other for some time and it is real nice to have him before the committee.

**STATEMENT OF HON. HENRY W. MAIER, MAYOR OF MILWAUKEE,
WIS., ON BEHALF OF THE U.S. CONFERENCE OF MAYORS**

Mr. MAIER. Thank you, Mr. Congressman.

Mr. Chairman, I am Henry Maier, mayor of Milwaukee. I am appearing today on behalf of the U.S. Conference of Mayors, the organization of some 600 American cities with a population of 30,000 or more. I appear in the capacity of chairman of the advisory board of the conference. Our concern for the development of sound social security and social welfare policies goes back to our earliest beginnings in the 30's, when Frank Murphy, then mayor of Detroit, and Fiorello LaGuardia, then mayor of New York, who helped found our organization, were among this Nation's strongest advocates of the social welfare programs that emerged in those years.

While our concern has continued over the years, we have in recent times, as an organization, assessed our welfare problems and resolved to modernize the present system to meet present-day circumstances. In June, 1968, for example, Mayor Carl Stokes of Cleveland, introduced this resolution at our annual conference, which was adopted:

"The U.S. Conference of Mayors calls upon Congress to enact the following programs: (1) A program to provide at least 1 million public service jobs for needed social services. Funds should be included to implement the improved coordination of all manpower programs at the local level. (2) A national system of income supplements for all people unable to work and whose incomes fall below the officially recognized definitions of poverty."

At our annual meeting last June, the U.S. Conference of Mayors again adopted several resolutions on welfare reform. We resolved that one of the priorities requiring "immediate attention" is restructuring and modernizing the welfare system. We called on Congress "to set forth national standards with complete Federal funding for the welfare program," and we again urged adoption of a national system of income supplements.

Our support for these new principles, especially for income supplements at national minimum levels, is motivated by our increasing awareness that the present social security and public assistance systems are falling behind national economic and social requirements. Your committee, Mr. Chairman, is, of course, more aware of these trends than most of us and, I am sure, is in a better position to evaluate them.

I need not cite burdensome statistical summaries repeating what you already know. Simply stated, it is certainly our basic recognition that the twin revolutions that have been occurring in our farm economy and in our manufacturing technology have caused a huge population to move from the farms to the cities, where it is harder and harder to compete for jobs requiring higher and higher levels of education. Furthermore, an increasing share of the blue collar jobs is moving to the suburbs. This process has placed a disproportionate financial burden on central city governments, since welfare costs rise as blue collar jobs decline. A recent study in the Milwaukee and six other metropolitan areas, for example, revealed that nearly a million new jobs became available in suburban rings from 1948 to 1968. At the same time, the central cities in the same areas were gaining only 60,000 new

jobs, a ratio of more than 15 to 1, and these jobs were primarily in finance, insurance, real estate, and services. In manufacturing alone, the seven central cities lost 150,000 jobs while the suburban rings around them gained 250,000 new manufacturing jobs.

For example, in Milwaukee County between 1963 and 1968, we suffered a net loss of 93 manufacturing firms while the other three counties of our SMSA gained 103 manufacturing firms. During the same period we managed to gain 27 manufacturing firms but this compares to a gain of 580 firms for the other three counties of our SMSA.

Parenthetically I would like to point out that we are beginning to witness industrial losses from older suburbs to newer suburbs similar to a game of economic "musical chairs". Actually, the central city of Milwaukee itself has had better luck than most other central cities. In fact, we have had a noticeable increase in our industrial and commercial assessment inside the central city despite the continuing industrial decentralization. Although we are fighting a good battle—and we were the first city in the country to set up a local division of economic development, a municipal division—we recognize we are bucking well-established trends, and we don't know what the future holds. I would also caution you that ours is an atypical situation not matched by the experience of many other big cities.

Those seeking work in the central cities are increasingly the new migrants to the cities with inadequate educational preparation. The mayors know at first hand the urgent need for reform in the welfare system. Sixty percent of the urban poor, for example, live in just 48 central cities. These same 48 cities contain half of the Nation's 5 million urban substandard dwelling units. They contain 80 percent of the urban Negroes, seven of them have more than 50,000 Spanish-speaking people.

The welfare burden in the central cities is crushing. As of last February, for example, 43 percent of all Wisconsin's welfare cases were concentrated in Milwaukee County, a county that has only 25 percent of the total population of the State. Poverty-linked costs for services in the city of Milwaukee have now reached \$31,320,906.

While every mayor has been distressed by the civil disorders of the past several years, and while all of us have been redoubling our efforts to cope with the conditions that have produced them, we have become increasingly mindful of the fact that income disparities are widening. The frightful thing about Watts was not only the large number of families subsisting on welfare but that they are not subsisting at decent levels and that so many viewed the welfare system as degrading. Dependency of the very old and the very young has overtaxed our public assistance and social security system in its present form. The financial cost to city and county government has simply outstripped revenues available from the property tax to provide adequate levels of living for our low income citizens. Public assistance programs cost local governments more than a billion dollars a year. The cost to State governments is about \$2 billion a year.

Let me underscore for the committee the financial crisis that is facing our cities and counties:

Because population shifts and growth in our cities have generated fantastic demands for new services in education, health, public safety, sanitation, police, and the like, local government payrolls jumped from

\$696 million in 1950 to \$3.5 billion in 1968—a fantastic sevenfold rise. During the same period, the Federal payroll rose from \$613 million to a little over \$2 billion.

Moreover, if we use constant dollars, local debt more than doubled between 1946 and 1966, while Federal debt actually declined.

In turning to the issues and legislation currently before your committee, Mr. Chairman, I believe you will agree that the cities have a fundamental stake in national policies on social security and public welfare. For this reason, we are heartened by the willingness of the new administration to advance proposals that have opened up a new level of public discussion on how to improve our present system. From the point of view of the cities, the ills and weaknesses of present programs have become too great to tolerate.

The benefits of the present social security system are too low and must be substantially increased. The system must be made universal, including those older people who for various reasons have been ineligible for insurance under social security. The eligibility ages for both men and women need to be lowered in light of the present unwillingness or inability of industry and commerce to hire older workers. The present categorical public assistance programs are unnecessarily restrictive in light of present conditions. We know that your committee will be guided by these concerns, and we are confident that your deliberations will produce a scale of benefits at adequate levels.

At the same time, the present general assistance programs being financed by State and local government have become totally inadequate, and, given the present financial crisis facing local government, there is no possibility of any substantial improvement, levels of benefit are too low. Millions of dependent and helpless children and older people receive no benefits and, worst of all, too many of the poor are members of families whose head is working full time. Millions of families and individuals are subsisting at levels below human decency and below the standards that they have a right to expect from a truly comprehensive social security and public assistance system.

Moreover, Mr. Chairman, both our national minimum wage legislation and our unemployment compensation systems have fallen behind the times. Both need strengthening as to levels of payment and scale of coverage. Both must operate under uniform national standards. If these systems were working at proper levels and with adequate coverage, they could make their proper contribution to the Nation's social welfare system—a contribution they are not now making.

We believe, Mr. Chairman, that the time has come to establish a broad family assistance program including income supplements at national minimum levels.

We, therefore, respectfully urge your committee, Mr. Chairman, to develop a new approach and new standards for our Nation's social security. We hope that the new system will take cognizance of the following needs:

1. The problem is national in scope and should be accepted as a national responsibility. All public costs involved in both the social security system and the public assistance system should be borne by the National Government. The recent Federal Supreme Court decision reaffirming a national open migration policy with respect to local residency requirements for welfare recipients punctuates the necessity for this recommendation, and I might add, parenthetically, Mr. Chair-

man, to that statement, that it is folly to expect a tax that was designed for the simple functions of fire, and garbage, and sewage, the property tax, to carry the burdens and the problems of poverty, and health, and crime, and education. And this is the load that the property tax is being expected to carry in most of the central cities of America.

The fiscal problem permeates every problem these local governments have and is definitely related to what we call the urban crisis, and it seems to me that there has been an oblivion to the fiscal situation as it really exists at the bottom of our political ladder in the United States of America.

2. In constructing a family assistance program, we urge the committee to approve levels of benefit above those recommended by the administration. We think it should be obvious that the proposed \$1,600 minimum is inadequate. We are confident that your studies and those of the Heineman Commission on Income Maintenance will demonstrate the need for an improved level of benefits. Now is the time, or so it seems to us, for us to elevate our national goals and our national morality. It is also the time for us to realize that educating our children in our slums in families without adequate income is impossible. No amount of compensatory education can cope with poverty, but with minimum levels of family income, public education can be restored to the role it deserves in our American democracy.

3. The coverage of the assistance program must be comprehensive, regardless of the family status of the recipient. There is no justification for Government policy producing disparity and discrimination among our citizens whether they are old or young, whether they have children or not.

4. Minimum standards for income allowances should be established on a national basis. Regional inequities engendered in part by the inability of some local and State governments to shoulder their responsibility are aggravating urban problems in some other localities. In Milwaukee County, in an intrastate situation, for instance, last February we found that the average welfare case cost \$192.61 monthly, compared to a State average grant per case of \$153.29. This is the situation that exists in an economy that is relatively prosperous. Thus, it is becoming increasingly obvious that disparities in welfare benefits have been among the reasons that people with low skills migrate to big cities.

5. Eligibility criteria and standards should be both uniform and as simple as possible. An income level below \$3,000 for a family of four, for example, accompanied by a simple statement of financial need, would be less expensive to administer than many of the systems now being used.

6. Adequate day care facilities and services must be provided to strengthen the workability of training programs if the job opportunity process is to succeed. Training and employment assistance programs should be available to all members of recipient families to encourage self-sufficiency.

7. If the committee believes that the family assistance program should require that adult recipients accept suitable jobs if offered, we hope that the administrative system that is used in job processing will afford individuals the right of appeal from arbitrary administrative judgments. We also expect that those bona fide jobs that are available

to the private sector will be subject to the minimum standards of the Fair Labor Standards and Minimum Wage Acts.

In conclusion, Mr. Chairman, let me reiterate that the cities, as well as the dependent and poverty-stricken, need your help as you reform the welfare system. The opportunity to eliminate poverty is also an opportunity to improve the quality of life in our cities. We are confident that if the National Government makes the commitment to eliminate poverty under the circumstances I have outlined today, the leaders of our cities will respond with a comparable effort and increased resources to improve the quality of urban life.

The CHAIRMAN. We thank you very much, Mr. Maier, for bringing to us your statement and that of the U.S. Conference of Mayors. I am sure that you are speaking at least for all the mayors of the large central cities because others that I have talked to who are in that capacity have made similar statements to me in the past.

Any questions?

Mr. Burke?

Mr. BURKE. I wish to commend you for your excellent statement. I think you have outlined the problems of the urban areas of the country, and I would like to ask you just one or two questions. One is in relation to old age assistance where the Federal Government contributes approximately 65 percent of the cost throughout the country.

Do you believe that it would be beneficial if the Federal Government assumed 100 percent of the cost inasmuch as the States pay about 50 percent of the 35 percent and the local communities carry the cost of about 50 percent of that 35 percent?

Mr. MAIER. Let me say this, Mr. Burke, I think that as a matter of national urban policy we are long overdue in our analysis of what functions the Federal Government should be carrying totally and what functions the States should be carrying totally. I cannot answer your specific question because I would say that it relates to a broader analysis of what the States should be bearing and what the Federal Government should be bearing and what the local governments are bearing, but I would like to say this, if I may, Mr. Burke, that the overlooked problem related to the central cities of America, and the things again that have precipitated the urban crisis, is the lack of a proper urban policy that analyzes what functions should be borne by whom.

Let me restate my thesis originally. We are trying to bear the problems of urban renewal and poverty-lined costs and health and welfare for our citizens on a property tax and the people that are bearing the brunt of this according to the last Federal census, 1960, are in an income class between \$6,000 and \$7,500, who bear the brunt of the load of this.

I mentioned Milwaukee's over \$30 million that we are spending on direct costs of poverty linked activities. The brunt of this is being borne on a property tax by people in an income class of \$6,000 to \$7,500.

For instance, if you examine the total composition of a city like ours, 707,000 people, you will find that we have 75,000 people at the poverty level in the nonaged bracket. Then we have another 72,000 people that are on fixed incomes, people that are over 65, and 40 percent of the 72,000 people are living at the poverty level. So that takes us in the range of 150,000 people out of a population of 707,000, and the vast

majority of the people outside that are people in the lower middle income range.

This is a monstrous burden that they carry on a property tax, and this \$30 million is property tax, again I say a tax that was originally designed for fire, and sewage, and garbage.

So any use of the richest source of taxation that we have in the United States related to the most universal application, the income tax, any use to relieve this situation is a tremendous boon to the problems of urban American.

Mr. BURKE. Thank you.

I would like to point out another field that I have had a great deal of interest in. In fact, I am like a voice crying in the wilderness on it, the child welfare problem in this Nation, where the Federal Government only contributes 6 to 9 percent towards the upkeep of these children who are wards of the State. They are the most disadvantaged children in the country, and your State is carrying its share of the burden, about 94 percent of it, my State is, and many of the local communities are faced with many problems concerning these youngsters who are placed in foster homes.

I was wondering if you could prevail upon the mayors of the country whom you meet to see if they can influence the Federal Government, the administration and the Congress, to raise its levels on financial payments.

This year the authorization is \$110 million but they are only spending \$57 million.

Now, even if they raise it up to \$110 million and expended that much, it would only produce about an 18-percent contribution on the part of the Federal Government, but I think it would help relieve the burden on the States which indirectly affects the urban areas, too.

Now, I agree with your statement because in the city of Boston we have a tax rate of \$144 on a thousand dollars assessment of real estate and this is a terrible burden on the homeowners in the area and, as you have pointed out, these people are not even in the middle income bracket. They are down below the middle income bracket, and they are being called upon to carry an unconscionable burden. I agree with your statement here and commend you for it.

Mr. MAIER. Thank you, Mr. Burke.

The CHAIRMAN. Mr. Byrnes?

Mr. BYRNES. Mr. Maier, what is an SMSA area?

Mr. MAIER. Standard metropolitan area.

Mr. BYRNES. Standard metropolitan—

Mr. MAIER. Statistical area.

Mr. BYRNES. On page 4 of your statement, you refer to welfare services in the city of Milwaukee reaching \$31 million.

Mr. MAIER. That is an error. That should be corrected. As I read the statement I corrected that. That should be "services," period. That is not welfare. That is \$31 million.

Mr. BYRNES. Poverty linked services?

Mr. MAIER. Poverty linked services, that is correct.

Mr. BYRNES. Is that the burden of the city or is that the general cost within the geographical area?

Mr. MAIER. That is the exclusive burden of the city property taxpayer.

Mr. BYRNES. What do you include in that?

Mr. MAIER. I include welfare, which is—

Mr. BYRNES. Let's take them one at a time. The general assistance program—do you include old age assistance, aid to the aged, aid to the blind?

Mr. MAIER. That is the general welfare cost.

Mr. BYRNES. No. What I am trying to get at is whether that is the city cost. Do you have the property taxpayers in the city of Milwaukee paying for the county share of the old age assistance program?

Are you including the amount of the county's cost for old age assistance, or are you taking the total figure of old age assistance paid within this area? Which?

Mr. MAIER. The \$31,320,905 relates only to the city property taxpayer as a payer, does not relate at all to any suburban payment. The figures relates to \$11 million of overall welfare payments, anything that can enter into the welfare category, and is related to the city property taxpayer.

The balance, the other two-thirds, relates to our crime costs which are related to poverty and poverty linked, and related to our educational costs which are poverty linked, and our health costs which are poverty linked, or things that come under the health department. For instance, Milwaukee has—which is financed exclusively by the city of Milwaukee—a health service, a special function service which we pay for exclusively from the property tax for which we get no Federal aid nor do we get any State aid. That kind of thing is in the \$31 million, and these are direct costs.

We have never analyzed this for indirect costs. We haven't done a real job of cost accounting on this that we call the poverty linked budget.

Mr. BYRNES. It does include, though, that proportion of the—let's take one program—old age assistance program, which in Wisconsin is chargeable to the counties.

Mr. MAIER. Yes.

Mr. BYRNES. It does include that?

Mr. MAIER. It does include that.

Mr. BYRNES. But it doesn't include any of the other contributions as far as the old age assistance program?

Mr. MAIER. No, sir.

Mr. BYRNES. Not State or the Federal?

Mr. MAIER. What it does include is any program for which we pay a property tax in terms of matching either State help or Federal help.

Mr. BYRNES. There is no question of the problems that urban areas face today with the exodus of the higher income people to the suburbs, leaving within the city the lower income and the working poor and the nonworking poor as the problem of the city. But this figure, it did occur to me, appeared to be quite large, and I was wondering, you don't make an allocation, for instance, of the cost of your police force between poverty-inspired needs and nonpoverty, do you?

Mr. MAIER. No.

Mr. BYRNES. You have thrown your whole police budget into this figure?

Mr. MAIER. Oh, no.

Mr. BYRNES. Oh, you haven't?

Mr. MAIER. No. Our police budget is \$24 million, our total police budget in the city of Milwaukee.

Mr. BYRNES. So you have tried to, by some rule of thumb, make an allocation?

Mr. MAIER. That is correct. We have a pretty tough allocator, too, Chief Pryor.

Mr. BYRNES. The committee has before it a proposal for a family assistance program as a substitute for the present program of aid to families of dependent children. It also would include families of the working poor where there are children present. It seems to me that this is a rather substantial change in Federal responsibility in relieving local responsibilities, a substantial move in the direction of some of the things that you are talking about in your statement, and yet you don't make any reference to it, or even suggest that we should develop a family assistance program.

I would like your view as to the specific proposal that is before the committee in that area.

Mr. MAIER. Well, of course I was making specific reference to the proposal and this I would judge to be the bulk of my testimony, but I was trying to give the rationale related to a central city as to why I believe this proposal is important.

Mr. BYRNES. You do think it is a step in the right direction and a substantial improvement?

Mr. MAIER. I not only think it is a step in the right direction, Congressman; I think it is one of the most important steps in the right direction the country can make. I did say that I didn't think the sum we are dealing with here is by any means adequate, but I can't think of another thing we have done related particularly to the cities, and I relate particularly to the cities, anything we have contemplated doing, that could be considered more significant than this.

My own feeling is that this could have a most important revolutionary effect on our society in the next 10 years.

Mr. BYRNES. And at least as far as it does go, it has the approval of the conference of mayors?

Mr. MAIER. In advance of the proposal we were most specifically on the record in this direction.

Mr. BYRNES. Now that you have the proposal, what I am trying to get you to do is to address yourself to the specific proposal.

Mr. MAIER. That is why I am here, and I did address myself to the proposal. I said that the proposal is certainly a definite step in the right direction, but inadequate in its dollar amounts for consideration, and I say inadequate because it at least seems to us, Congressman, once you go through a civil disorder, once you have to administer the sad outcome of a civil disorder, you certainly start contemplating if you are levelheaded, so it seems to me, and I don't say this is true in all cases with all mayors, but I say it is true of most of the mayors of the country, that there have to be some changes.

For instance, with a relatively open space non-dense housing situation, you could only relate Watts, which had about the second greatest number of welfare checks in the world for that particular area and that particular density, you can only relate that thing to two things: You can relate it to welfare and the fact that it wasn't working, and to the job transportation situation. Now, the job trans-

portation situation is the thing I am hitting in this testimony when I say that what is happening in these large central cities such as Los Angeles, that the jobs are moving away from the inner cores of the city or the depressed areas of the city, and I think this was a definite conclusion, I think it was an underscored conclusion, by every study that I have seen of Watts, that this is a real problem in this thing, and that related to this problem is the depression that is associated with receiving a welfare check.

What you have before you and what will come in the Heineman study, I think, is going to be one of the most important considerations that could be made in our country as it relates to the problems of the urban crisis, the crisis in our cities.

So if I failed to impress you, Mr. Byrnes, with the fact that I was speaking heavily and underscoring and endorsing the principle of this proposed legislation, I am sorry.

Mr. BYRNES. I wasn't sure, because I got the impression that you were talking about family assistance and the various things in the administration's proposal and yet you steered clear, it seemed to me. I wasn't sure whether you were also addressing yourself—

Mr. MAIER. I want to clear up that doubt.

Mr. BYRNES. (continuing)—in approval of the basic approach and the general objectives and mechanics of that program, and I gather you were.

Mr. MAIER. Yes, sir.

Mr. BYRNES. Thank you.

The CHAIRMAN. Mrs. Griffiths?

Mrs. GRIFFITHS. I would like to congratulate you, Mr. Maier. I think you have made a good analysis of the problems of the cities.

Personally, I support the idea of the Federal Government taking over the entire welfare system and paying the full bill. I think this is the business of the Federal Government. I think it is not too unreasonable to say they ought to pay for the total bill in education, too. It would help greatly in all of the States, but I suppose we don't have the money to do all of these things. Nevertheless, I think we ought to go that way.

But I would like to ask you, all these years we have been talking about the integration of black and white, and I support that, but don't you think really the time has come to discuss the integration of the rich, the middle class, and the poor? What is really happening in the cities of America is that you are leaving the poor and the lower middle class. They are the same people who have paid 90 percent for those roads that have taken the rich and upper middle class out of town. Why don't the mayors come in with a suggestion that where Federal money goes that community must also take its share of the poor, that is, if there is an FHA, if there is a road bill, if there is any type of loan made from the Federal Government or any guarantee or any money coming in, that so many houses must be built there for the very poor. What is wrong with that?

Mr. MAIER. The mayors have taken a very definite position on that, very specific. As a matter of fact, I am the author of the first resolution that entered the U.S. Conference of Mayors and it caused quite an uproar. This was at Dallas about 5 years ago, doing exactly what you are talking about, that the Federal Government could correct an awful lot of urban problems if it would exercise the carrot and the

stick as you are suggesting. I am a member of the New Towns Commission—you have a bill in the Congress which is a related proposition—to help relieve the local communities.

Further, the mayors went on record the last time very specifically calling for the introduction of legislation related to the proposition you are talking about and other related propositions and the very important idea that wherever you have the presence of low income persons and you can prove a loss in property value through their presence and related to a Federal program, that you can then be compensated.

What this does, in effect, is if there is a real fear and you do have a property value loss, you are then compensated. If you are bluffing, then the bluff is called, but you are quite right, Mrs. Griffiths, this what I consider the No. 1 problem.

There is an income imbalance in these central cities. There is an overload of the poor, and we have no way of rectifying this situation except through State action, which you aren't going to get, or through the Federal use of the carrot and the stick.

Mr. Chairman, you can solve an awful lot of problems for us if you could convince the Congress.

Mrs. GRIFFITHS. Why should we run roads, federally paid for roads, where the Federal Government is paying for 90 percent of it, out to a community outside of Detroit where the cheapest home is \$50,000? Why don't we require them to take their share of the poor? In place of that, what we get in Detroit is a lot of people outside Detroit calling back to tell us who to vote for; you know, where are you calling from?

Mr. MAIER. That has a familiar ring.

Mrs. GRIFFITHS. One of the problems that I heard explained by one of the librarians in the city of Detroit, which has one of the great libraries of the country, is we finally had to charge outsiders for using it if you lived outside the city of Detroit. And she said that the first complaint was by some man in a downriver community, saying, "What do you mean I am going to have to pay a dollar and a half charge? I own \$40,000 worth of Detroit-Edison stock."

You know, he is supporting Detroit.

Well, anyhow, this is the way I think we have to go or we are dead. Thank you, Mr. Chairman.

Mr. MAIER. I couldn't agree with you more.

The CHAIRMAN. Any further questions?

If not, we thank you again for coming to the committee.

Mr. MAIER. Thank you very kindly, Mr. Chairman, and I would like to thank the members of the committee for their courtesy.

The CHAIRMAN. Thank you.

Mr. MAIER. Thank you.

The CHAIRMAN. Mr. McNerney is our next witness.

Mr. McNerney, you have been before the committee many times in the past, but again we will ask you to identify yourself for this particular record.

STATEMENT OF WALTER J. McNERNEY, PRESIDENT, BLUE CROSS ASSOCIATION; ACCOMPANIED BY BERNARD R. TRESNOWSKI, SENIOR VICE PRESIDENT

Mr. McNERNEY. Thank you, Mr. Chairman.

My name is Walter J. McNerney. I am president of the Blue Cross Association, the national organization of Blue Cross service plans, and I appear here today as a representative of those plans. I have with me Bernard R. Tresnowski, senior vice president, Blue Cross Association, who is in immediate charge of Government programs and who will assist in answering any questions members of the committee might have.

The CHAIRMAN. We are glad to have both of you with us, and you are recognized.

Mr. McNERNEY. Thank you.

The Blue Cross system provides benefits to approximately 69 million subscribers in the United States, including more than 4 million Federal employees and dependents. In the medicare program, in addition, Blue Cross acts as intermediary chosen by more than 92 percent of the participating hospitals, 85 percent of the home-health agencies, and 58 percent of the participating extended-care facilities.

In 22 States Blue Cross plans have some contractual responsibility with the State to serve in either an administrative or combined administrative and underwriting capacity for title XIX. Blue Cross administers benefits in 33 States under the civilian health and medical program of uniformed services. We have underway demonstrations of Blue Cross involvement in model cities programs and are actively exploring ways to contribute effectively our services through neighborhood health centers and other programs designed for depressed areas.

I should like to comment on various aspects of the title XVIII and title XIX programs drawing on our experience as an administrator of these programs, and reflecting our experience in the administration of health-care benefits through the private sector.

We present these comments cognizant of the critical importance of these programs within the total scheme of health-care financing and delivery and their noteworthy accomplishments in this regard. Under medicare, the aged in this country have found dignified access to the health-care system. Title XIX has provided an opportunity to extend health benefits and their access to many of the disadvantaged in our society.

Our essential purpose today is to identify ways of improving titles XVIII and XIX through (1) greater simplification of benefits and methods and (2) building greater incentives for productivity.

As we proceed to identify problems and offer recommendations, it might be well to pause and take note of the effective collaborative effort between the public and private sectors demonstrated in the implementation of these programs.

In 1966, Congress promulgated the concept of intermediaries and carriers, primarily because title XVIII and, in some areas, title XIX could not have started without them. Also persuasive was the concept of harnessing existing expertise and systems rather than duplicating them. In implementing the concept, the administration wisely set forth

specifications and expressed them in the form of contracts subject to periodic audit, review and renegotiation.

The concept is implemented daily in other Government programs whether in the purchase of arms or butter. Experience to date suggests that the contracts under title XVIII and XIX have, in fact, preserved the important element of accountability while capitalizing on the assets of proven institutions. Further, however, the administrative costs have been conservative, and useful techniques and incentives emanating from Government programs have been applied to the larger area of private health benefits, just as the expertise derived from the private sector has benefited the Government programs through the media of daily contact and contract negotiation. What might not have been love at first sight has grown at least to a mutual sense of respect, if not to an innovative combination in which each sector has been stimulated by the other.

To support the recommendations that follow, I should like to summarize briefly some of the major problems facing the health-care system in general and those inherent in the medicare and medicaid programs specifically.

Two major problems stand out. The health field lacks productivity and accessibility.

Medicare and medicaid have highlighted both problems. A significant portion of the new money generated by both programs was absorbed by inflation, and many of the widely varying morbidity, use and cost patterns seen within and among communities persisted after the programs took hold. In terms of access, both professional manpower and health institutions are still unevenly distributed or fragmented. As a result, a regrettable minority do not or cannot gain entry into the system or, once in it, if they can afford it, exploit it properly.

The committee is aware of the documentation, for example, of such facts as: Less than 50 percent of new expenditures in health services over the past 5 years have resulted in new services, the poor having two times the infant mortality rate of the average population, and the concentration of nurses varying on a scale of 4 to 1 per 100,000 population by State across the Nation.

It is important too for all of us to recognize that the system is not self-regulating, being conspicuously free of the forces of a free market, and it is, like most high-labor enterprises, peculiarly vulnerable to the forces of inflation, under the best of circumstances.

How to introduce control into such a system is complicated at best and, currently, is the subject of a great deal of concern. Most involved can agree quickly that whereas there are no easy solutions, more imaginative moves, in the realm of incentives and controls, must be taken than have been taken to date.

As dispensers of approximately \$8.5 billion in 1969, the medicare and medicaid programs have a significant role to play. It would be unconscionable if either or both were to stand aside from the problems of productivity and access or, worse, through system or method, further complicate the inherent problems. A first order of business is not the expenditure of more money; it is the proper expenditure of the money available. In fact, large amounts of new money precipitously spent might well have the impact of solidifying the present system instead of stimulating it to change.

Many approaches need to be taken. If a succinct overview were warrantable, it would stress such important ideas as: incentive reimbursement, areawide planning, corporate planning, organization of health services, utilization review, licensure and accreditation, delivery-system reasearch and development, and clearly enunciated health goals. Let me touch on a few of these lightly within the context of medicare and medicaid, while offering to share Blue Cross' experiences with the committee in greater scope and depth, as the committee wishes.

RISING COSTS

Many forces in the economy have accelerated health costs recently; for example, greater effective demand through prepayment, minimum-wage legislation, labor pressures for higher salaries, and a growing diversity of services largely additive rather than substitutive in nature. Medicare and medicaid simply added to the impact through the sheer weight of new purchasing power. For example, free service was replaced by physician payment.

While this simply underscores the importance of both programs accepting responsibility for selective involvement in the delivery system, two additional points should be recognized. One, the medicare beneficiary accepts part of the burden through part A deductibles and co-insurance payments and through higher part B premiums and copayments. Two, reasonably accurate prospective estimates of costs and use necessary for considered congressional action are and will be difficult unless matters change.

UTILIZATION REVIEW—BENEFIT ADMINISTRATION

Although utilization review has a great deal of potential, it requires sophisticated administration. Under medicare and medicaid, it is contemplated that health institutions will have peer review committees of medical staffs concerned on an ongoing basis with effective use of health services and benefit exclusions based on law or regulation. If, however, either program contemplates not paying for care judged ineffective on a case basis, the patient might get used as a pawn, for example, asked to pay the bill. Also, many providers, for example, consider it unrealistic for them to be left holding the risk where patients can't or won't pay.

The challenge is to design utilization review as a continuing administrative influence, as a means of broadening medical decisions to take into account quantitative as well as qualitative matters and as a working partner with benefit or claims administration. Essentially, it must be implemented and coordinated at the local level near the problems involved. It cannot, except by minimum standard, be regulated from a centralized platform.

The provisions in the present medicare law assigning primary responsibility to the medical profession for control over use have inherent problems. Under present law, utilization review committees are expected to upgrade quality of care and also monitor length of stay, use of services, and need for admission. All of the latter three potentially involve a lesser payment by medicare—for example, confined to what is appropriate. Institutional utilization review committees have developed U.R. plans to meet the form prescribed by the statute but

have not, in many cases, developed substantive actions of control, in part because of their reluctance to mix professional and economic functions. Our review of the certification, recertification and extended-stay review activities have revealed widely varying performance because of lack of understanding, variable commitment to utilization review as a peer-review mechanism, and rebellion against Government-generated criteria for medical necessity, among others.

On the other hand, our role as intermediary in claims review affecting use of services has been greatly augmented and developed. This is illustrated, for example, by the action taken by our Florida Blue Cross plan in withholding payments to Daytona Beach general hospital for protracted lengths of stay beyond those of similar hospitals in the community.

Considerable time and effort has been and will continue to be necessary to achieve understanding among beneficiaries and the medical community of the limitations established by legislation and regulations. A great deal of the problem develops out of what has evolved as an apparent conflict between the provisions of Section 1861(k) of the act concerning the role and function of utilization review, and section 1862 of the act which describes the exclusions from coverage under the program, and section 1814 which identifies condition of and limitations on payment of service.

PROVIDER REIMBURSEMENT—REASONABLE COSTS

The institutional reimbursement methods under titles XVIII and XIX have moved the provider field ahead considerably in regard to functional cost determination, a valuable tool for both management and reimbursement. However, the methods in other respects have had negative effects and need to be changed.

In testimony to this committee in March 1967, we commented on the administration of the reimbursement system under title XVIII to the providers of care referred to as the RCCAC concept. As a supplement to that testimony we were requested by the chairman to supply a copy of a letter from me that I had written to Commissioner Ball dealing with the relative merits of an RCC reimbursement formula and one based on average per diem. I shall not take the time of the committee now to review those matters because it is a matter of record.

However, I should like again to underscore the fact that the system of reimbursement developed under this program demands greater simplification. We have accumulated enough experience to demonstrate that the system is excessively costly to administer and has placed demands upon providers, intermediaries, and the Social Security Administration for data accumulation and auditing beyond the needs of determining reasonable cost.

Also, the use of RCCAC as a method of apportionment has included several alternative methods of computation with differing results based upon the alternative selected by the provider. Where, for example, one institution by selecting the combination method of apportionment received \$500,000 more than if it had selected the departmental method, a question of equity as well as reasonableness arises. The availability of alternatives was created to accommodate varying provider needs. The problem has been administering the result of the alternative within the framework of "reasonable cost" intended by the statute.

In cooperation with the Social Security Administration and the American Hospital Association, Blue Cross has sought to achieve, administratively, greater simplification through modifying many of the requirements through alternative approaches. Noteworthy has been the concept of limited auditing and combined auditing. As worthy as these attempts have been, we are convinced that a change in the method of payment to providers is essential.

The change must be designed not only to simplify the administration of the reimbursement systems but also to serve as a vehicle of control in the sense that it provides for greater predictability of financing and includes incentive systems designed to influence costs favorably. In this regard, we look forward to examining the results of the negotiations between the American Hospital Association and the Secretary of HEW.

Whatever the method, the provider must be put at risk under carefully defined and prenegotiated circumstances. The cost-plus or charge reimbursement formulas that we have seen since World War II cannot be justified in an essentially noncompetitive economy. Self-esteem is hardly an adequate discipline when billions of dollars are at stake.

No one method of reimbursement to accomplish the above stands out. Necessarily, the situation must be somewhat fluid while a better method or methods are sought out. We hope that HEW steps up its interest in identifying and evaluating various patterns with particular reference to the need to key off costs, and increase both incentive and predictability through prenegotiated limits within which the provider can live and innovate.

Negotiations must be undertaken in the light of a growing number of collectively bargained contracts between management and labor in provider institutions. The problem facing the Government between labor and product costs in other areas of the economy may emerge in full flower in the health field.

PLANNING AND OTHER DISCIPLINES

Concern with proper payment needs to be supplemented by the evolution of a more rational capital structure in the health field. HEW is in an excellent position to foster better areawide planning through making it conditional at the State and local levels in conjunction with matching grant or loan programs and through the reimbursement process where penalty payments are made in the absence of a institution fitting areawide plans, where such plans exist.

We need greater experimentation with various patterns or organization of services. For example, neighborhood health centers and health campuses. Under title XVIII or XIX there should be no prejudice in making payment to innovative forms. Further, through grants, new forms of innovation should be encouraged. The disproportionate amounts now spent on biomedical research and demonstration, as contrasted with experimental funds directed at the delivery system, is part of our inflationary and access problem.

ACCESS

The problem of access referred to previously relates partly to financing under titles XVIII and XIX and partly to the fact that care is

simply not available in some poor city or rural areas. Programs such as those under OEO need to be continued to overcome with reasonable dispatch the institutional inertias involved in the present system. Gaps will not be filled, particularly at the primary-care level, short of concerted efforts such as has characterized many neighborhood health-center developments.

WITH PARTICULAR REFERENCE TO MEDICAID

We recognize the Secretary of HEW has chosen to study title XIX and related programs. However, based on our experience and observation of this program, we can conclude that there have been basic problems in the areas of eligibility determination and the form of administration.

Problems of eligibility determination have occurred in both the criteria for and the efficient recording and communication of eligible recipients. Fundamental to this problem has been the complicated nature of Welfare Department eligibility determinations following application by the recipient and the lack of effective data systems to record quickly eligibility and communicate eligibility following a service query.

The problems of administration have been those related to claim administration and provider reimbursement and the effectiveness of these two activities on the exercise of controls. As previously described under the medicare program, claims administered has an intimate relationship to utilization review activities, and provider reimbursement systems are directly and potentially correlated with predictability of financing and incentive for controls.

RECOMMENDATIONS

Utilization review—benefit administration

We recommend that the Congress clarify, either through appropriate reference in this committee's report or, if necessary, through corrective language in the act, that the role of institutional utilization review committees is to function as a peer-review mechanism intended to insure more effective use of institutional facilities and services. And that benefit interpretation and criteria for administration of benefit exclusions should be promulgated by the Secretary and implemented largely through the Intermediary. The Intermediary should seek the assistance and consultation of existing peer-review mechanisms and encourage their development where they do not now exist.

Provider reimbursement

We recommend that, in the interests of simplification, the method of allocating provider costs to program beneficiaries be revised to a per diem cost basis with appropriate adjustments related to factors specific to the aged population. We also support the expansion of the scope of experiments and demonstration projects to develop incentives through methods of financing for economy in the provision of health services. The maximum use possible should be made of the variations in method that now exist and that can be expanded or elaborated in given localities with good prospects of significant local participation. We further urge that the process of authorizing demonstration projects

be simplified as much as possible to avoid delay due to forms, procedures, et cetera.

We recommend that planning of health facilities be supported by these two programs by directing the Secretary to consider the actions of comprehensive health-planning agencies, areawide planning agencies, and regional medical programs in the development of payment methods taking into consideration provider-participating status under planning.

In support of this approach, recognition should be given to any transition phase where planning is in a developmental status, where there is an absence of appropriate planning data and technical skills.

We recommend that the existence of a capital plan and operating budget in provider institutions be a condition of participation in the program. Capital plans should be reported to the appropriate planning agency where review and/or approval is requested.

We recommend that provider payment not exceed charges with appropriate recognition of collections from nonindigent patients. We urge that the definition of costs should be designed so the program pays for the cost of program beneficiaries as well as an appropriate share of standby and community costs.

Medicaid

We recommend that the regulatory pattern developed under title XVIII be made applicable to the title XIX program in such areas as provider standards, definitions of service, and reimbursement of providers.

We recommend to the extent feasible that patterns of administration demonstrated as effective and efficient under title XVIII be adopted by title XIX in such areas as claims administration, eligibility recording system, provider audits, utilization review, and data accumulation.

OTHER COMMENTS AND RECOMMENDATIONS

Experience from our daily involvement in the administration of these programs has highlighted the need to either clarify administrative authority, simplify benefit design, streamline administrative procedures or underscore congressional intent. The following specific comments and recommendations are offered to explain and correct these matters.

PROGRAM INTEGRITY

Certain questionable and improper provider practices have been identified and grouped together under the term "program integrity." These include potential fraud cases, medical services billed for which were not provided to the beneficiary, duplicate billing for the same services, and medical services which would be excessive or inappropriate in terms of the patient's diagnosis.

Issues involved in this aspect of program administration involve separation of honest clerical error from intent to defraud the program, adequate provider control of internal accounting and billing procedures as well as practical development of standards for claims review which would protect the program and not unreasonably burden or delay processing of the very large volume of claims. There are also concerns inherent in designing claim forms which acceptably balance

requirements of minimum information necessary for claims review prior to payment and the imperatives associated with prompt processing and payment of claims.

Considerable effort has been directed to a resolution of these issues in order to achieve necessary understanding and commitments needed to insure uniform administration and reasonable control.

RECOMMENDATION

We support the extension of authority to the Secretary to discontinue payments and move to immediate decertification of providers and suppliers of service for reasons of misrepresentation of material fact in application for payment and failure to provide information to determine payment. Further, we urge caution in the establishment, under Government auspices, of medical-peer review intended to evaluate the quality of services. Rather, we suggest further support of existing peer-review mechanisms.

HOSPITAL-BASED PHYSICIANS

In our testimony before this committee in March 1967, we highlighted the widespread difficulties in administration associated with the inclusion of hospital-based physicians under part B programs. We underscored the unnatural need to compute professional and administrative components and the resulting requirement to submit separate bills for these services.

The Congress recognized this problem by providing through the 1967 amendments for combined billing for radiologists and pathologists. This amendment greatly simplified administration and returned these two hospital-based specialists to their natural framework for billing. However, there are other physicians who work in the hospital where the previous requirement of separate billing continues to exist—for example, cardiologists, neurologists, physiatrists, and attending physicians characterized as supervising physicians in a teaching setting. This situation has not only created problems of administration, but has permitted the possibility of payment for the same services under both the part A and part B trust funds, such as occurred at Cook County Hospital in Chicago.

RECOMMENDATION

We recommend that the provision for combined billing now available for pathologists and radiologists be extended to all hospital-based physicians, including attending physicians in a teaching setting where arrangements exist between the physician and the hospital.

In accordance with the provisions governing radiologists and pathologists, we recommend elimination of the \$50 deductible and coinsurance provisions for all other hospital-based physicians, including supervising physicians in a teaching setting.

INSTITUTIONAL BENEFITS UNDER PART B

Institutional outpatient benefits are included under part B of the program, subject to the \$50 deductible and coinsurance. Also, ancillary services provided by hospitals are covered subject to this deductible and

coinsurance. In addition to the home-health benefit available under part A of the program, there is an additional 100 days available under part B, with a different criterion for admission and with a deductible and coinsurance factor. All of these part B benefits, although functioning under differing program requirements, are administered by the part A intermediary and are all reimbursed on a reasonable cost basis.

There are fundamental administrative problems in providing what are essentially part A benefits financed out of the part B trust fund. These include, for example, the need to establish separate eligibility queries and different benefit criteria under home-health services.

RECOMMENDATIONS

We recommend that all hospital outpatient services be part A benefits, subject to a straight 50-percent copayment by the beneficiary with the maximum payment of \$20 for any series of related billings by the same hospital and a minimum billable medicare benefit of \$2.

We recommend that all part B health services billed for by the hospital, including ancillary services be covered under part A, with the elimination of the \$50 deductible substituted with an appropriate copayment.

We recommend that home-health services provided under part B be transferred and appended to home-health part A benefits subject to the same requirements of eligibility.

EXTENDED CARE SERVICES

The requirement of a 3-day qualifying stay in a hospital prior to transfer to an extended care facility was written into the act to support the concept of extended care benefits as an extension of hospital services. There has been widespread misunderstanding of this concept and the extended care benefit by beneficiaries, providers and physicians.

RECOMMENDATION

We recommend that the 3-day qualifying hospital stay be retained and that in retaining this provision of the act, the Congress clarify its intent concerning the meaning of extended care services as an extension of hospital services as contrasted with nursing home care.

INTERNS AND RESIDENTS IN NONAPPROVED TRAINING PROGRAMS

Presently some hospitals use physicians who are principally graduates of foreign medical schools to perform what are generally intern and resident duties. Since these physicians do not perform under an approved training program, it has been determined by the administration that salaries paid to these physicians are not educational costs and therefore are not reimbursable under part A. Because these services represent a part B benefit, it has been necessary for the provider to develop a per diem charge against which the coinsurance is charged to the beneficiary.

RECOMMENDATION

We recommend that the services of interns and residents in non-approved training programs be considered as part A benefits subject to reimbursement on a reasonable cost basis.

OUTPATIENT PHYSICAL THERAPY

A new benefit for outpatient physical therapy was included among the 1967 amendments. The language of the amendment to the law established coverage for such services when furnished to a beneficiary "as an outpatient." Because of that particular phrasing to the amendment, the program will not permit a provider qualified to furnish physical therapy, to furnish such service to its own inpatients, but will permit that provider to obtain physical therapy services for its own inpatients from another medicare provider. This results in two providers, both qualified under the program to provide physical therapy, having to make an arrangement with each other to exchange physical therapy services, in order to qualify the beneficiary for payment of the service.

RECOMMENDATION

We recommend that the language of the law and the intent of Congress be clarified to avoid such illogical and unnecessary arrangements between providers.

DURABLE MEDICAL EQUIPMENT

Currently, durable medical equipment may either be rented or purchased under the program. However, the decision to rent or to purchase may only be made by the beneficiary. This results in instances where the beneficiary elects to rent an item of durable medical equipment for a year, in spite of the fact that if the rental allowances were paid toward purchase of the equipment, the item would be entirely paid for in 6 months. Therefore, the program pays in rental charges twice what would be necessary if the equipment would have been purchased.

RECOMMENDATION

We recommend that the program requirements be changed to permit intermediaries to determine, based upon evaluation of the period of time the equipment will be necessary, whether that equipment will be purchased or rented and to make acceptable financial arrangements where the beneficiary is unable to advance funds to purchase medically necessary durable equipment.

I thank you for the opportunity of presenting this statement, Mr. Chairman. Blue Cross is proud of its role under title XVIII and XIX, and we stand ready to help advance these programs in terms of their effectiveness and their efficiency.

The CHAIRMAN. Mr. McNerney, we appreciate very much your coming to the committee. You are always extremely helpful to us with the problems involved in title XVIII and XIX. I have just a few questions that I want to ask.

First, what should the medicare and medicaid programs do about access to care and productivity? I am asking you because apparently

in the operation of the Blue Cross plans you have done something that we have not done here with respect to medicare and medicaid.

Mr. McNERNEY. In terms of access under both of these programs, one of the problems is that there seems to be a great deal of misunderstanding or lack of clarity at the State level as to whether, for example, these programs were meant to pay for care in neighborhood health centers or in community health centers. This has been variously interpreted, and I think that the law makes it possible, and some people are saying at the local level that having not had clearance on this that it is impossible, so as a result the funds that you have either through trust or general tax revenues put at the disposal of either aged or aged poor or other poor are not being brought to bear on some of these worthy community facilities.

I think that is one thing that should be clarified. Perhaps this committee could comment on it as part of its deliberations. Access beyond that, I think, is a matter of spending the money, which will shortly be \$7 to \$8 billion, to encourage growth where it doesn't exist and probably won't exist without some outside stimulation, that is, to throw the weight of this money behind areawide planning, and the thesis there, of course, of areawide planning, is to be concerned not only with where there is duplication but where there is a gap.

In other words, given two hospitals and applying for expansion, the one that fills the gap would get the accent, and even some of these areawide planning agencies working hand-in-glove with regional medical programs will even promulgate the idea of an institution where none now exists. Putting the purchasing power of these programs behind that type effort helps considerably, as does penalizing those institutions that try to persist even though they are not provable in meeting a community need.

So the trick, of course, is to view the expenditures of these moneys less in the nature of a bank transaction and more in the nature of a judicial realization of how they impact on the delivery system.

The CHAIRMAN. From what you said, I would gather that you do favor the administration's proposal to tie medicare reimbursement to areawide planning bodies.

Mr. McNERNEY. We do.

The CHAIRMAN. Do you do that, aside from medicare and medicaid say, in your own operation?

Mr. McNERNEY. We do it in the following way.

Let me say first we do it less than I would like to see it done, and we have more to do. But in a handful of plans, perhaps six, there is specific reference made to this in the contract or in the administration of the contract. In some 50-odd plans we participate in areawide planning, either through providing expertise, serving on the board, putting up money, providing data to facilitate the operation of these, which are prefatory steps, really, to taking that final step of making payment conditional on them. So we are part of the way there working toward a much deeper involvement.

The CHAIRMAN. It is my understanding that at least some of your Blue Cross plans in some of the States pay hospitals on the basis of cost. Is that right?

Mr. McNERNEY. Yes.

The CHAIRMAN. I am talking about other than your relationship to medicare.

Mr. McNERNEY. I understand.

The CHAIRMAN. We thought that was what we were setting up when we established the medicare program, that we would pay on the basis of cost. Why aren't your plans apparently having as much trouble with cost reimbursement as we seem to be having in medicare?

Mr. McNERNEY. Well, if you take simply the administrative part of this, aside from the control part of it, I think the problem comes in that the apportionment formula chosen under medicare is unfortunately complicated. You either through an overall or a compartmentalized scheme use as an apportionment mechanism the relationship of charges to the aged, charges to the other patients. That establishes a ratio which you then put against your cost.

The problem is that the charge information available in hospitals is very spotty and therefore difficult to audit. To be sure that you have the charges right, to derive that information from the hospital, and to apply it to cost all involves a series of 13-to-20-some-odd steps, which traded against a program of 20 million people adds up to an input that is greater than it is worth.

I think what we have to is to use a more simplified method of allocation. For example, one could apply against the average per diem cost some factor that took into account that the aged had more intensive care, and that factor could be reevaluated every 3, 4, 5 years. But to do it on a one-by-one, case-by-case basis or to accumulate it off that type of thing, as I say, creates an administrative cost, a paper cost, which far exceeds any potential equity that it might have.

So I think that step is highly desirable and that we in Blue Cross have always taken the point of view that the average is a simpler and easier way to go. Not only is it simple, but it avoids the game that is played of experience rating with patients, that is to say, should the aged participate in the nonaged expenses? Well, should the young participate in the young-married expenses? Should the person who is very ill and needs intensive care be pulled out and not pooled with the fellow who is less ill?

The Government will meet itself coming around the barn, because it is going to be paying for young people soon and middle-age groups. Is it going to experience-rate them in a payment sense? Well, possibly the most dramatic stroke of all is to recognize we are all in this together and as long as we are careful about what costs we pay, that we use an average per diem and then, correspondingly, put a lot more pressure on such ideas as incentives in payment so that everybody benefits.

The CHAIRMAN. You are aware of the fact that every time the actuaries look at costs of medicare, they have raised their estimates? You are aware of the assumptions made in September of this year, are you not?

Mr. McNERNEY. You would have to be specific. There have been a lot of assumptions made.

The CHAIRMAN. Well, in September the actuary looked at it again, and he decided that he had raised the percentage of cost increase in 1969 over 1968 by too little an amount. So he has adjusted that upward to 15 percent now for 1969, upped the one for 1970 to 14 percent, which will probably be 15 percent before he gets through looking at it next year, 13 percent for 1971, and then subsequently by declining

amounts until a stable annual increase of 4 percent is reached in the years after 1977.

When we enacted this program in 1965, we were told by the actuaries that the per-beneficiary cost would be \$158 in 1970. This September estimate has now raised it, along with the other estimates in the intervening period, to an estimated annual per-beneficiary cost of \$255.

Now, just since 1965 that is an increase of 60 percent in the estimated cost of the program per person for 1970. We apparently have not done a very good job of being able to contain costs in this program.

I wonder if you have had that same experience in your own business.

Mr. McNERNEY. We have had very similar experience. It is characterized by dealing with the total population instead of a select population as under medicare, but it is similar. And if I may comment on it very briefly—

The CHAIRMAN. I want you to tell me, because I understand you have done a better job in your own operations of controlling costs than we have done in the program.

Mr. McNERNEY. Some of the publicity we have gotten recently makes me a little defensive on that point, but we are trying. At any rate, we are aware of a growing discontent in the private market, from management, from labor, that in the fact of new expenditures, for example, since 1965 in the health system less than half have been translated into new services. The rest has been absorbed by inflation. And that is the heart of the problem. That is where we missed.

In medicare and medicaid, dumping \$7 billion into an unproductive system, which was already overheated, was bound to cause an impact of this sort, and many of us were not wise enough to see the enormity of the impact. Our actuaries feel, quite independently—this was as recently as a couple of days ago—that we probably should expect on our present course increases of the order of 14 percent next year, 1970, and up to 14 percent in 1971.

Now, I think the point I would like to underscore is this, and that would assume, incidentally, very little change in the use patterns in terms of any significant amount.

I think this simply makes it very, very clear that it is imperative that the money be spent with controls and incentives which heretofore have been too lightly applied. This is, in other words, what we can expect in the future ad infinitum almost unless some intervening steps are taken through areawide planning, incentive reimbursement to bring it back down.

And the reason is a very simple one. It is noncompetitive economy that doesn't correct itself automatically. These factors have to be introduced from the outside. So I say that is not so much the problem of the actuary as it is the problem of those of us who have responsibility for organizing and financing the care. It is almost as we will it.

I hope that we can introduce some of these controls. If we do, then I would be optimistic that there would be a deceleration in cost. If we don't, I am less optimistic than I was.

The CHAIRMAN. Mr. McNerney, if we take your advice and include interns in nonapproved training programs under part A of medicare, as you have suggested, would that result in further stimulating the hiring of graduates of foreign medical schools?

Mr. McNERNEY. I don't think so, if it is made clear that all we are talking about here is an administrative transaction. I wouldn't say that they should be folded in under approved training programs. I am just saying they would be treated as an "A" benefit instead of going through the artificial business of trying to allocate some cost to them and then paying them as a "B" benefit.

Leave them to stand out for what they are, not members of the teaching program, but build them through the "A" and pay them through the "A."

The CHAIRMAN. Merely an administrative change that you are recommending?

Mr. McNERNEY. Right.

The CHAIRMAN. I misunderstood.

Mr. McNerney, do you favor all of the provisions proposed by the administration for cost effectiveness in medicare?

Mr. McNERNEY. I think if I had any reservations about those, it would center on the one that seemed to imply that the Secretary would interest himself pretty directly in quality of care. I forget exactly the reference, but there would be suggested the promulgation of State and regional peer review mechanisms that would, yes, look at what goes on in terms of effectiveness, but also would be concerned with quality.

Now, my own view is that if the medical profession is confronted that directly with quality in the sense of, is this man practicing the best medicine, that there would tend to be a digging in the heels, rigidifying points of view. And some have inventive ways found around what we are trying to accomplish here, that it would be better to come up on this subject through the portal of effectiveness totally rather than through quality.

Now, this is somewhat of a spurious differentiation, but let me tell you what I mean, that is, that we get the physicians to negotiate some parameters of proper use by diagnosis and then let those be applied by the intermediary or the carrier. In this way cases are kicked out and then dealt with by area committees or by hospital committees so that there is always a judicial weighing of special circumstances. Is the care needed? Is it excessive in length? But this action should stop a step short of telling a physician that he should have kept the patient 5 days when he kept him 4, because someone's opinion over here is such-and-such.

The state of the art of medicine is not yet that definitive. Medical schools don't preach the same practice, the same length of stay. And I think to come in on it would perhaps lose us ground as opposed to the path we are now on. Otherwise, I think that the Secretary has proposed some appropriate provisions.

The CHAIRMAN. Mr. McNerney, would it be asking too much of you to ask you to submit for the record information about cases on which Blue Cross has withheld payment, either because the hospital stay was no longer necessary, say, or because the services provided were not needed? You have withheld payment?

Mr. McNERNEY. We will provide you with what information we have.

(The information referred to follows:)

EXHIBIT I.—BLUE CROSS ASSOCIATION (ALL PLANS) DENIAL OF CLAIMS FOR FISCAL YEARS 1967, 1968, AND 1969, UNDER THE MEDICARE PROGRAM

Period covered	Hospital inpatient		Hospital outpatient		ECF		HHA	
	Number processed	Claims denied	Number processed	Claims denied	Number processed	Claims denied	Number processed	Claims denied
Fiscal year 1967-----	5,093,267	10,341	3,331,223	41,511	188,208	1,565	496,186	3,516
Fiscal year 1968-----	6,020,909	25,940	5,575,509	132,429	591,554	9,383	906,302	10,367
Fiscal year 1969-----	6,401,539	30,294	6,452,779	193,832	681,631	28,100	1,138,534	9,492

¹ ECF coverage started Jan. 1, 1967. These figures represent only 6 months' coverage.

Note: Denials include (1) Services provided were not covered; (2) duplicate bill for previously received bill; (3) individuals not eligible for hospita insurance.

Source: Above data taken from monthly Intermediary Workload Report (SSA-1566).

The CHAIRMAN. I am asking that because it is actually the increasing utilization, in my opinion, more than the actual increase in cost of care that has put the hospital fund in the red to the extent that it is in the red.

Am I partially right or totally incorrect?

Mr. McNERNEY. I find it hard to differentiate as to which is the more consequential, but obviously use is something we have to concern ourselves with, particularly, can this be better done in another facility that is less expensive or on an ambulatory basis? But the per diem cost is also a major factor.

The CHAIRMAN. I think you were in the room this morning when Mr. Kee and his friends from West Virginia testified in favor of the inclusion of the disabled beneficiaries, cash beneficiaries, being included in the medicare program.

Do you favor this idea?

Mr. McNERNEY. The including of the disabled under social security in a medicare type program?

The CHAIRMAN. Yes.

Mr. McNERNEY. Let me make this one qualification. I think that the needs of the disabled are quite unique. I think it would be a mistake to talk about the same benefit structure automatically applied with the same rules and regulations behind it.

We heard examples that were not completely typical of the aged population that medicare devotes itself to, but given an opportunity to develop a benefit structure that was pertinent, I would say that this is a desirable thing.

The CHAIRMAN. Would you help me by submitting for the record your thoughts with respect to what the benefit structure should be, the components of it?

Mr. McNERNEY. I would be glad to.

(The information to be supplied follows:)

BLUE CROSS ASSOCIATION,
Chicago, Ill., December 8, 1969.

DEAR MR. MILLS: This letter is in response to my November 5th commitment to the House Ways and Means Committee to provide our suggestions regarding a benefit program for the disabled. The scope of such a program must take into account (1) eligibility, (2) hospital-medical-rehabilitation needs, (3) availability of services, facilities and manpower, (4) estimated cost and method of financing.

1. ELIGIBILITY

The terms "disability" and "disabled" are defined by the Social Security Administration (*Social Security Survey of the Disabled: 1966*), to categorize the disabled population as:

Severely disabled.—unable to work altogether or unable to work regularly.

Occupationally disabled.—able to work regularly, but unable to do the same work as before the onset of disability or unable to work full time.

Secondary work limitation.—able to work full time, regularly, and at the same occupation but with limitations in the kind or amount of work they could perform in their jobs. Women with limitations in keeping house, but not in work, were also classified as having secondary work limitations.

The Social Security Survey of the Disabled: 1966, provides the following data in respect to the population in the age range 18 to 64. The figures shown *exclude* an estimated 700,000 adults in long stay medical care institutions and approximately 400,000 adults, generally disabled, for six months or less.

[Whole numbers in thousands]

Age	Total population	Nondisabled	Disabled			
			Total	Severe	Occupational	Secondary work limitation
Total.....	103,085	85,332	17,753	6,100	5,014	6,639
18 to 34.....	40,574	37,399	3,175	706	738	1,731
35 to 44.....	23,693	30,306	3,387	1,104	954	1,329
45 to 54.....	21,896	16,823	5,073	1,516	1,787	1,770
55 to 64.....	16,922	10,803	6,119	2,774	1,536	1,809
Percentage distribution						
Total.....	100.0	82.8	17.2	5.9	4.9	6.4
18 to 34.....	100.0	92.2	7.8	1.7	1.8	4.3
35 to 44.....	100.0	85.7	14.3	4.7	4.0	5.6
45 to 54.....	100.0	76.8	23.2	6.9	8.2	8.1
55 to 64.....	100.0	63.8	36.2	16.4	9.1	10.7

The total of *severely disabled* is understated to the extent of the 700,000 institutionalized adults and approximately 130,000 of those disabled for six months or less. (The last figure, 130,000 was derived from the proportions shown for the three degrees of disability).

Income maintenance for the severely disabled population shown above (6,100,-000) is distributed as follows:

	Total	Percent	Disability		Other OASDHI	
			Number	Percent	Number	Percent
OASDHI.....	1,625,000	26.5	847,000	13.9	778,000	12.6
APTC.....	710,000	11.7				
Other public funds.....	498,000	8.2				
None.....	1 3,268,000	53.6				
Total.....	6,100,000					

1 75 percent of these are married women.

It is important to note that 778,000 severely disabled are served under other than the disability provisions of OASDHI. These are 363,000 early retirement beneficiaries and 415,000 dependents and survivors of retired, deceased and disabled workers.

The present eligibility requirements militate against inclusion of most of the severely disabled in the OASDHI disability income maintenance program. If the same eligibility requirements are used for any contemplated health care program for the disabled, an estimated 86 percent of the severely disabled would fail to qualify for service. Medical requirements and insured status are both limiting factors to entry into the OASDHI disability income maintenance pro-

gram. "Disability" is defined (in part) by SSA for purposes of entitlement to disabled workers benefits as:

The inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

Insured status requirements are:

20 quarters of coverage during the 40 quarter period preceding disability or if under 31, one half the quarters from age 21 to date of disablement with a minimum of six quarters coverage attained. To obtain benefits a worker must have been disabled for at least six full calendar months. Vocational rehabilitation services are available to applicants through state agencies. Such services may be paid from the Social Security trust funds under a variety of qualifications, but one in particular deserves note.

"D. It is reasonably predicted that the beneficiary's period of productive work, after he is rehabilitated, will be long enough so that the cost of his rehabilitation services will be offset by the savings in benefit payments, and the additional contributions to the trust funds from his earnings."

In general, the disability income program criteria for eligibility does not satisfy the needs for a broad program of medical care services for the disabled as established under Part A and Part B of the Medicare program.

Disabled persons are required to wait a minimum of six months before becoming eligible for services. The early period of disability is typified by acute medical expense, sudden reduction in living income and rapid exhaustion of health care insurance. Acute medical care should be included through a system of qualification for disability health care coverage earlier than six months of injury, through physicians' judgment and certification.

2. MEDICAL NEEDS

During our short discussion of care for the disabled, on November 5th, I indicated that Medicare (Title XVIII) benefits would not fulfill the broad medical needs of the severely disabled. Medicare benefits are primarily geared to care of acute illness and minimal aftercare. Extended care and home care provisions are only supportive of the acute in-hospital care provided.

The severely disabled require medical management in reference to the total needs of the individual, medical, psychological, social and vocational. Necessary services include nursing, physical therapy, occupational therapy, speech therapy as well as social and psychological services. Training and education to cope with the activities of daily living ranks high as a necessary service. Evaluation of the home environment should be considered in such a program to determine special or essential equipment needs of the disabled person. The program should also include necessary hospital and medical care for general illness not related to the primary disabling condition.

3. AVAILABILITY OF SERVICE, FACILITIES, AND MANPOWER

Some of the above described services are available in some acute care hospitals. However, these institutions are not generally geared to the task of medical management of the severely disabled person's needs. Many could develop adequate programs given the funds and manpower required. At present there are about 400 medically oriented rehabilitation facilities in the U.S. of which about 70 have been accredited by the Commission on Accreditation of Rehabilitation Facilities of the JCAH.

A brief definition of the type of facility required to accomplish the objectives of a health care program for the disabled has been developed by our Michigan Blue Cross Plan and states in part:

"For purposes of these qualifications a rehabilitation facility is described as one operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of medical, psychological, social and vocational evaluation and services under competent and continuing medical direction. These services should offer to the extent needed, intensive care to those treatable patients whose medical, physical, and social condition affords reasonable promise of regaining some fair degree of self-sufficiency."

Clearly there are few facilities presently that could meet these standards. Manpower such as rehabilitation oriented physicians, physical therapist, oc-

cupational therapist, speech therapist, audiologists, vocational counselors, social workers, psychologists and others are both in short supply and fragmented in their availability.

Financing a program of benefits for the disabled must take into account the need to influence the availability and organization of facilities, services and manpower.

4. COST AND FINANCING

We did not attempt to consider the matter of cost and financing because of the need to answer the other matters first. When cost and financing are considered there will need to be careful analysis of administrative patterns and their cost for a tailored benefit program. Also, we would urge that deductibles not be considered and that co-payment be substituted.

SUMMARY

Our examination of the issues surrounding a health benefit program for the disabled highlighted the magnitude of disablement in our population. By identifying these matters in our comments on eligibility, we simply call your attention to the rather large group of disabled who would be left outside the Social Security System. These comments are all without reference to Programs of Workmen's compensation or private insurance and prepayment programs for the disabled.

For OASDHI recipients, there is the present waiting period of six months which leaves unanswered the matter of meeting the medical needs during this cooridor period. We have suggested a reconsideration of this waiting period on the order of a shorter waiting period subject to Physician Certification to meet the very real acute medical needs of the severely disabled.

The pattern of benefits we have suggested as being included in a program for the disabled are those bridging both the acute and long-term nature of disabled health care needs.

Finally, we note that in conjunction with a benefit program for the disabled, there must be a parallel development of specialized facilities, otherwise money will be spent in a largely unproductive manner.

Sincerely,

WALTER J. MCNERNEY.

The CHAIRMAN. Taking into consideration not just the cases that we heard this morning, because it would apply across-the-board to all of our disabled if we include them, have you made any studies in connection with the operation of the Blues of the cost of extending this assistance to those that are disabled under 65?

Mr. MCNERNEY. I don't know the answer to that.

Barney, do you know?

Mr. TRESNOWSKI. No, but we do, of course, cover the disabled in many of our private programs.

The CHAIRMAN. Are your policies for them higher than policies for people 65 and over?

Mr. TRESNOWSKI. We don't experience-rate on the basis of the disability. It would be the community rate in terms of the group they happen to be in.

The CHAIRMAN. You have a policy on the entire family, not just the worker?

Mr. TRESNOWSKI. That is right.

The CHAIRMAN. And you do issue that kind of policy for the same services at the same cost to that family, do you, as to the family over 65?

Mr. TRESNOWSKI. That too is correct.

Mr. MCNERNEY. If they can afford it.

The CHAIRMAN. I understand, if they can buy. They can buy, though, at the same price?

Mr. MCNERNEY. Yes.

The CHAIRMAN. We have been told in the past by the Social Security people, HEW people, that the utilization by the disabled would be many times more than the utilization by those 65 and older.

Mr. McNERNEY. There are some good data on that that Louis Reed and others have uncovered, and you are right, I would expect, depending, of course, upon the definition, you would find significantly greater utilization. I would expect it, offhand, to be a multiple, just like the aged is a multiple of the average population.

The CHAIRMAN. You have been very very helpful to me, and I appreciate so much your responding to my questions.

Mr. Byrnes?

Mr. BYRNES. Mr. McNerney, you have mentioned several times, and we have heard it on numerous occasions, the need for incentive reimbursement or incentives to encourage reduction of cost. And I think a good share of your statement was directed to the idea that we have to be more innovative in the whole hospital structure.

But what are some of the specifics of incentive reimbursement? I mean specifically, what really are some of the people talking about who use that term? What do they have in the back of their minds?

Mr. McNERNEY. Let me give you about three or four prototypes.

One, a program that Blue Cross just kicked off in southern California, with the support, incidentally, of HEW, not financial but moral support and permission to involve titles XVIII and XIX. There they have sent engineers into hospitals—I am talking about industrial type engineers—to pin down what would be efficient ways of performing tasks such as nursing, dietary, or whatever. They developed standards so that one could calculate if he knew the patient load through extrapolation how much staff it should take to do a good job in taking care of these patients. Then payment will be made so that those who can do it that way, or even a little more efficiently, would get to keep a certain amount of the difference between what the average was in the area and what they incurred. And, similarly, those that went beyond it would be penalized a bit.

This is a technique of developing work standards and relating payment to them so that an administrator and his hospital could keep certain gains or pay certain penalties according to his ability.

Another approach which we see is a target rate. There, the hospital sits down with the Blue Cross plan or with some other payer and negotiates a flat rate. Here everybody argues about what it should be, but then there is a commitment made and the institution must live within that for some protracted period of time. And it has the incentive of ordering the work so that it meets that limit. We find an approach something like that in Connecticut.

New Jersey is beginning to move into a budget type scheme where there is a preapproval of the budget by the person paying the bill before the year begins. And there they argue about various things. Beyond that, you go into a whole host of niceties, such as this year's increase in cost over last year's cannot exceed for any individual institution such-and-such percentage of the average for all institutions, or if somebody's length of stay is reduced through judicious use of the institution, any gains in lower length of stay is reflected in greater payment.

At the moment there is a seeking along these paths. These are real-life situations, the last one St. Louis, for example. It boils down to putting the provider at some risk. After all, if he is not under risk, what is his incentive for efficiency? Secondly, when the House Ways and Means Committee makes a commitment for a new program with greater predictability, you can understand what the cost will be. The only way to do this is to confine a man to some sort of a limit during the course of that period.

These are the types of things, Mr. Byrnes, that we see now. None is widespread enough. It is all in a state of innovation and experimentation. And it is for that reason I would hope the situation could remain fluid while encouraging further innovation through Federal money before any crystallization takes place.

Mr. BYRNES. We have permissibility now, don't we, for the Department to enter into incentive-type operations?

Mr. McNERNEY. And that has been helpful in getting a few of these I have mentioned off the ground, although I have to say that the field has responded too slowly to the Secretary's challenge. We have had something like four or five substantive applications.

I hope we will get some further applications beyond those that we have already put in in the near future.

Mr. BYRNES. In another area, you made reference to the problem that is created by attempts to allocate costs to the aged.

Mr. McNERNEY. Yes.

Mr. BYRNES. Have you any figures as to results in terms of a factor of differential, in our payments experience?

Mr. McNERNEY. Let me give you two answers to that.

One, how does the average payment under the program relate to an average per diem? Barney, what is that spread?

Mr. TRESNOWSKI. That is over a dollar's difference between combination RCC and average per diem.

Mr. McNERNEY. This allocation saves, if you will, a dollar on the average.

If I could make the next statement on how much it costs to administer—and you hear all sorts of things, for example, administrators saying, "I have more clerks than I ever had just keeping track of all this information." I don't think anybody knows, but the estimates run pretty high by some people, who say they know. That is to say, that the cost of paperwork now in hospitals is 17 to 19 percent of the total cost.

Now, that doesn't tell you what the increase is as a result of this formula, but the administrators in several of the hospitals feel that it is substantial and that, as opposed to a dollar's difference here, a more streamlined method might more than make up that difference.

Mr. BYRNES. I am surprised that it is so relatively small in a sense.

My concern was that what we were going to do was to impose additional expenses on the nonaged. It was an unfair situation if the lower cost in one area would simply be shifted then to the rest of the population.

But I assume that differential has not caused a significant shift.

Mr. McNERNEY. We have to add that the differential will vary by institution depending upon its patient load in terms of aged and

other. That is an average figure which describes a range. So any given institution could be either better off than that or worse off.

Mr. BYRNES. You suggest that we move to the average cost with a set differential. It almost suggests you might even forget about that, because of the problems that would be entailed in the equity as between one hospital against another hospital.

Mr. McNERNEY. In my letter to Mr. Ball in 1966, I expressed myself to this effect. I concur that both in terms of equity and in the matter of how much payoff you get for all the effort you put in, I think one should give real thought to average per diem as a base from which to develop incentives, and I stand on that letter.

Mr. BYRNES. Thank you very much.

The CHAIRMAN. Any further questions?

Mr. Vanik?

Mr. VANIK. I have a question about entry of private corporate hospitals into the field. This would have the effect of making the economy a little bit more competitive.

What is your reaction to that? I think competitive services might produce some good, might produce higher quality, but what is your view about that?

Mr. McNERNEY. You are talking about the entrance of the proprietary—

Mr. VANIK. I am talking about proprietary hospitals who can come in and maybe provide higher quality services at even a lower price. How else are we going to measure quality of service if we don't have some encouragement for this kind of thing?

Mr. McNERNEY. Let me give you what I hope isn't an excessively equivocal answer. But first let me say that there is no question that some proprietary hospitals have filled gaps. If they hadn't moved in, the care wouldn't have been available.

We have seen some of that in New York, southern California, et cetera, and that is good. However, there is a potential problem involved because some of the proprietary corporations, whether it be nursing home or hospital, have hit upon the scheme of involving, first, a group of physicians on the staff who would be in on the investment, second, eschewing to the extent possible complicated cases, not taking on education—

Mr. VANIK. Taking the prime cases and leaving the high-cost items to the public hospitals.

Mr. McNERNEY. Right, so there is, in effect, a skimming process.

Mr. VANIK. In a community where you are the carrier, you can practically control their eligibility, and can't you require that they meet a certain standard of service which will include the willingness to take the broad spectrum of cases? They can't operate if you don't clear them, can they?

Mr. McNERNEY. I think a better way of going at it would be through licensure. The carrier's clout isn't that great. He has no legal sanction behind him. Wouldn't it be better to have the comprehensive areawide planning that has been promulgated by the Government and regrettably not fully implemented? There has been a reluctance to talk about what its authorities are.

Wouldn't it be better at the State level to give that body the right that banking groups have had for years. That is, some say over whether an institution could exist or not?

What I contemplate is an areawide planning scheme built on voluntary lines that exhorts and supports hospitals, works with them professionally to assume responsibility, but at the State level that there be a binary yes-no decision that could be made after the local filtering. It seems to me it takes that order of influence in order to do it.

Now, unfortunately, under Public Law 89-749 everybody stops short of that, and so the game goes on. But I don't think you can really expect, for example, a carrier that might have 15 to 20 percent of the population enrolled, or maybe 30 percent, to say, "We are not going to pay you," and have that stick.

Mr. VANIK. You are handling 92 percent of the hospitals. How many claims are you handling under medicare and medicaid? You are handling most of them, aren't you?

Mr. McNERNEY. I would say it is roughly the same proportion.

Mr. VANIK. I have been concerned with various standards for communities so that a case might be eligible for service in one area and might be denied in another.

What do you do to try to bring about a uniform concept?

Mr. McNERNEY. First, the Blue Cross Association, with which both of us are associated, spends a great deal of time with its member plans on this very point, trying to be sure that the language is understood and that the decisions made are reasonably equitable.

I would be less than candid with you if I didn't admit that that is a difficult process, because the medical practice patterns in this country vary considerably and these differences are deeply felt. The configuration of institutions for instance, varies considerably. We are however, making a persistent effort in this regard.

Of course, it is always important for HEW to be very clear what it wants in the first place, and there are situations where that lack of clarity enters the picture, too.

Mr. VANIK. Let me ask you this. Of the claims that you are handling under both medicare and medicaid, what percentage do you have to charge for administration now? What does it come to?

Mr. McNERNEY. Let's keep them separate. Under medicare, title XVIII, our intermediary cost is 1.14 percent, which seems to me to be a fairly good bargain in terms of the amount of work done and effort exerted. That is out of a total administrative expense for the program of 3.1 percent.

Under medicaid I don't know the answer, and I am sorry I don't. This is a State program, and I am sure it varies considerably by State, because the programs vary by State.

Mr. VANIK. Is it higher or lower?

Mr. McNERNEY. I would imagine it would be higher, because there you are talking about a more comprehensive set of benefits, many of which are small and repetitive and take more input in order to administer them.

My guess would be that it would go up towards 7 percent, something of the sort, but I really should try to get that information. If you would like, I will.

Mr. VANIK. I would appreciate it.

Mr. McNERNEY. And I will submit it.

Mr. VANIK. I would appreciate it, Mr. Chairman, if we could have that in the record. I was wondering also if we couldn't have your documentation on a full year's experience.

Mr. McNERNEY. All right.

Mr. VANIK. On both programs.

Mr. McNERNEY. All right.

(The information referred to follows:)

EXHIBIT II

BLUE CROSS ASSOCIATION (ALL PLANS) SUMMARY OF COSTS FOR MEDICARE PROGRAM (REPORTED COSTS FROM PLANS FOR FISCAL YEARS ENDED JUNE 30, 1967, JUNE 30, 1968, AND JUNE 30, 1969)

	Costs and bills processed	Percentage to benefit dollars	Per bill processed
FISCAL YEAR 1967			
Total costs.....	\$29,211,005	1.29	\$3.74
Benefit dollars paid.....	2,277,132,584		291.44
Administrative costs.....	27,079,795	1.19	3.47
Provider audit costs.....	2,131,210	.10	.27
Bills processed.....	7,813,341		
FISCAL YEAR 1968			
Total costs.....	\$49,166,950	1.48	3.75
Benefit dollars paid.....	3,321,128,072		553.93
Administrative costs.....	38,111,597	1.15	2.91
Provider audit costs.....	11,055,353	.33	.84
Bills processed.....	13,079,078		
FISCAL YEAR 1969			
Total costs.....	\$65,373,519	1.58	4.76
Benefit dollars paid.....	4,128,619,069		300.92
Administrative costs.....	47,168,436	1.14	3.44
Provider audit costs.....	18,205,083	.44	1.32
Bills processed.....	13,719,820		

EXHIBIT III.—BLUE CROSS MEDICAID ADMINISTRATIVE COST DATA

Plan	Reporting period	Benefit payments	Number of claims	Adminis- trative cost	Adminis- trative cost per claim	Adminis- trative cost as of percent of benefit payment
Los Angeles, Calif....	Apr. 1, 1969, to Sept. 30, 1969....	\$151,281,814	814,755	\$1,227,877	\$1.50	\$0.80
Oakland, Calif.....	do.....	97,148,510	615,062	834,248	1.35	.86
Milwaukee, Wis.....	do.....	54,552,400	369,867	306,934	.82	.60
Pennsylvania.....	1968.....	74,500,000	207,000	358,682	1.73	.48
Topeka, Kans.....	July 1, 1968, to June 30, 1969....	26,369,938	1,722,747	713,521	.414	2.70
Dallas, Tex.....	Apr. 1, 1969, to Sept. 30, 1969....	25,076,662	787,732	1,415,473	1.797	5.64
Des Moines, Iowa....	Jan. 1, 1969, to July 1, 1969....	15,680,992	615,207	614,922	.995	4.08
Denver, Colo.....	Apr. 1, 1969, to Sept. 30, 1969....	4,132,539	58,083	165,983	2.85	4.02
Albuquerque, N. Mex.....	Apr. 1, 1969 to Sept. 30, 1969....	5,985,470	119,120	219,824	1.845	3.672
St. Paul, Minn.....	1968.....	3,728,640	19,079	66,231	3.47	1.78
Wilmington, Del.....	Jan. 1, 1969, to June 30, 1969....	1,844,167	107,228	122,334	1.14	6.63
Sioux City, Iowa....	July 1, 1968, to Dec. 31, 1968....	599,628	5,393	12,142	2.25	2.02

Mr. VANIK. Let me ask one other question. In your reserves, are your investments made in hospitals or not? Or are they just generally made?

Mr. McNERNEY. Our investments are governed by State law, and the State—

Mr. VANIK. In every State they vary?

Mr. McNERNEY. State law varies, but let me say two things.

One, the whole philosophy of Blue Cross is not to derive income off investments. It turns its money over very rapidly. To the extent we invest it, it is largely conservative investment, where the emphasis is not on tremendously high yield.

Mr. VANIK. Is there any bar to your investment being made in institutions so that we can help take some of the burdens of the Hill-Burton Act that create so much problem? In other words, couldn't there be a social motivation in the investment of your own resources to helping more facilities?

Mr. McNERNEY. I think that to use our money to invest in institutions might raise some questions of propriety, which, offhand, I would be tempted to duck.

On the other hand, one could challenge us with this thought. How about using some of the money to support innovative patterns? The justification would be that it would have a favorable impact on our expenditures in total.

We haven't done this, although I must confess at times we were sorely tempted to do it. For example, if we could contrive a more efficient way of rendering care to a given population, put some risk capital into it—maybe we are close to that.

Mr. VANIK. One final question. Do you have any information on this? Where one of your organizations is the carrier, does it have the power generally to determine which hospitals will be dealt with as claimant, and does it have the authority to refuse?

For example, can the carrier in a given area refuse to accept a claim from a given hospital for a reason other than reasonableness of charge or quality of the service?

Mr. McNERNEY. Are we talking about our role—

Mr. VANIK. An individual carrier in a given area.

Mr. McNERNEY. Are we talking about our role under medicare or in the private market?

Mr. VANIK. I am talking about the role under medicare.

Mr. McNERNEY. Under medicare, our authority in that regard is pretty much determined by regulations established by the Secretary. He has increasingly set forth certain conditions under which payment should or shouldn't be made. But if it is not a matter of reasonableness—

Mr. VANIK. Doesn't he rely on your judgment in a given area? As I understand it, he goes back to you and says, "What do you folks say," and if you say "no," the institution is out of business.

Mr. McNERNEY. That is within the realm of reasonableness. My answer was in terms of reasonable cost we do have a charter from the Secretary to determine that with certain guidelines.

Mr. VANIK. I said, if the cost is reasonable and if the quality of the service is high, do you have any other basis on which you can just refuse to recognize a given institution's claim?

Mr. McNERNEY. The law says, if I recall correctly, that if it is an aberrant amount compared to other institutions in the area, we could disclaim it. And we did this in Florida recently and made it stick. But I think the hospital deserved it under the circumstances.

Mr. VANIK. You have arbitrary power then, don't you?

Mr. McNERNEY. To that extent we do. Of course, it has to be supported ultimately by the Secretary. You see, each institution affected has appeal rights and a regular ladder of appeal exists, not only within the system of medicare but also outside it in the courts.

Mr. VANIK. I have no further questions, Mr. Chairman.

Thank you, Mr. McNerney.

The CHAIRMAN. Thank you.

Are there any further questions?

Again we thank you, Mr. McNerney, for your testimony before the Committee.

Mr. McNERNEY. Thank you, sir.

The CHAIRMAN. Without objection, the committee will recess, to reconvene at 2 o'clock, with Mr. Henkel the first witness. Be here promptly at 2 o'clock.

(Whereupon, at 12:55 p.m. the committee recessed, to reconvene at 2 p.m. the same day.)

AFTER RECESS

(The committee reconvened at 2 p.m., Hon. Richard H. Fulton presiding.)

Mr. FULTON. Our first witness for this afternoon session is the Council of State Chambers of Commerce, represented by Mr. Paul P. Henkel, chairman, and Mr. William R. Brown, secretary of the Social Security Committee.

We welcome you to the committee and, if you will identify yourself for the record, you may proceed with your testimony, sir.

STATEMENT OF PAUL P. HENKEL, CHAIRMAN, SOCIAL SECURITY COMMITTEE; ACCOMPANIED BY WILLIAM R. BROWN, SECRETARY, SOCIAL SECURITY COMMITTEE, AND ASSOCIATE RESEARCH DIRECTOR, COUNCIL OF STATE CHAMBERS OF COMMERCE

Mr. HENKEL. Thank you, Congressman.

I am Paul Henkel. I am manager of payroll taxes for Union Carbide Corp. but I am also chairman of the Social Security Committee of the Council of State Chambers of Commerce and I am appearing here today on behalf of the member State Chambers of Commerce of the Council who are listed at the end of our prepared statement and who have endorsed that statement.

Appearing with me on my left is Mr. William R. Brown, the Associate Research Director of the Council.

We thank the committee at the outset for the opportunity to appear at this hearing.

Mr. FULTON. Thank you, sir.

You may proceed with your statement.

Mr. HENKEL. Thank you, sir.

SUMMARY

SOCIAL SECURITY RECOMMENDATIONS

1. *Recognize the need to increase Social Security benefits*—to compensate for the increased cost-of-living, but oppose the automatic cost-of-living escalator. There is no substitute for periodic Congressional review of benefits and financing, at the same time, taking all pertinent factors into consideration, not just those that may be in an automatic formula.

2. *Support periodic review and adjustment of retirement test*—in light of changing economic conditions, but oppose automatic adjustment of the exempt earnings level. Support the Administration proposal to increase the annual amount of exempt earnings an individual may earn and still get full benefits from \$1680 to \$1800, but oppose proposal for a reduction of \$1 for each \$2 of all earnings in excess of \$1800 (suggest that the cutoff point for such one-for-two treatment be increased from the present \$2880 to \$3000).

3. *Support periodic Congressional review of financing*—tax rates and the wage base need to be considered together in light of current and short term benefit

costs, not just in relation to changes in wage levels, and higher benefit costs should be met primarily by raising tax rates rather than the tax base; therefore, we strongly oppose the proposed automatic increase in the taxable wage base. If Congress does not enact the proposed automatic cost-of-living increase proposal, there is no need for the automatic tax base increase proposal.

4. *New emphasis for a "tax rebellion" among middle income employees and self-employed might result from Administration proposals to shift a greater proportion of the Social Security tax burden to them.* This could follow from the proposal to raise the tax base, while reducing certain tax rates, so as to reduce presently scheduled tax increases for persons earning less than \$7800 and to increase them for those earning \$9000 or more a year. The inequity is compounded by the long time practice of providing proportionately greater benefits at the lower income level so that an increase in the tax base does not give a proportionate increase in benefits to those paying the higher taxes.

5. *Wage base increases provide for "overtaxation"*—HEW figures given the Committee indicate that our previous predictions of "overtaxation" resulting from base increases have been substantiated and that the present law will continue this overtaxation. We submit that there is no justification whatsoever for deciding at this time to raise the taxable wage base to \$9000 in 1972.

6. *Support Annual Social Security Wage Reporting*—suggest that the Committee and its staff investigate savings that could result both for the government and employers from annual rather than quarterly reporting of Social Security wage data.

WELFARE REFORM RECOMMENDATIONS

1. *Support "welfare reform"*—of the type that retains an important role for the States and not the "revolutionary" Family Assistance Proposal of the Administration. Such reforms, which have been supported by the Ways and Means Committee in the past, would include areas that are also covered in the Administration Bill—these are required work and training programs, child care and support services, retention of greater proportion of earnings, and incentives to the states to participate in the Unemployed Parent (UP) program of AFDC and to bring benefits up to the states' own standards of need.

2. *Oppose Federal Minimum Welfare Standards*—such as the \$90 minimum that has been proposed by the Administration for state welfare payments. This does not allow sufficiently for regional and state differences and for special conditions within states.

3. *Oppose the proposed prohibition against State Lien and Recovery and Family Responsibility Laws*—this is a matter that should be left to the determination of each state depending upon the attitude of the people.

4. *Oppose administration of "welfare" programs by the Social Security Administration*—"Welfare" should be administered at the state and local level and above all it should not be administered by the same agency that is responsible for maintaining the integrity of our "social insurance" system. Administration of "welfare" programs by the Social Security Administration could contribute to the further erosion of the "insurance" aspects of our "social insurance" system by making it more difficult to maintain a sharp distinction between the two approaches.

IMPLICATIONS FOR BUDGET CONTROL

The Administration proposals for increasing social security and welfare costs by \$8.8 billion during the first full year will greatly add to the problem of Congressional and Executive control of Federal spending that results from a rapidly increasing proportion of the Federal Budget being "relatively uncontrollable." If the concepts of family assistance and revenue sharing are adopted, the amounts suggested by the Administration seem likely to be no more than a beginning.

H.R. 14081—SOCIAL SECURITY AMENDMENTS OF 1969

10-PERCENT BENEFIT INCREASES

Section 2 of H.R. 14081 proposes to increase social security benefits by 10 percent effective January 1, 1970. It includes an increase in the minimum monthly benefit from \$55.40 to \$61 and an increase in the present maximum monthly primary insurance amount obtainable in

1970 from \$168.40 to \$185.30. It also provides for an increase in the ultimate maximum monthly primary insurance amount from \$218 to \$250—sometime after the year 2000.

Section 3 of H.R. 14081 further provides for a 10 percent increase in the special benefit to persons age 72 or more, so that a single person will receive \$22 instead of \$20 a month and a married couple will receive \$44 instead of \$40 a month.

The proposed 10-percent increase is based in part on the underlying contention that there has been roughly a similar increase in prices and the cost of living since benefits were last increased in February 1968. We support this contention and the proposed increases in benefits. Since we will later point out our objections to an increase in the taxable wage base and to any automatic increase of the base, we urge that the benefit formula and the table of benefits set forth in section 2 be modified so that future benefit computations be limited by the retention of the existing maximum annual taxable wage base of \$7,800.

We are cognizant of the apprehension of social security beneficiaries and retirees with private industrial pension benefits concerning the erosion of their real income because of spiraling costs and prices. We do not agree with the view, however, that generally our current social security beneficiaries and retirees are in distressing circumstances. Neither do we agree with the view that the Congress continually has lagged in adjusting benefits—both in terms of time and amounts. In fact, the 1967 CPI had risen 8 percent since the 1965 benefit increases, yet Congress enacted a 13-percent benefit increase effective early in 1968. Of more current importance is the fact that a 10-percent increase in benefits will approximate the increase in the CPI since 1968 when benefits were last increased.

We are aware that this committee, the Senate Finance Committee, and both Houses of Congress will have supporters of, and will be subject to, strong pressures for a greater percentage increase in benefits. A 15-percent increase is being sought by some at this time. In support of this, it is contended that benefits should be increased commensurate with increases in wage levels rather than prices. We believe this attempted correlation is not relevant and not appropriate. It is also contended that higher benefits can and should be financed from Federal general revenues. We oppose such action as it would weaken and ultimately destroy the historic principle of relating benefits to past earnings and could lead to complete “open-end” funding, to absorption of the social security tax into the Federal income tax structure, and to “runaway” benefits.

Automatic “cost-of-living” benefit increases: Section 4 of H.R. 14081 proposes a 3-percent increase in benefits, but not more than once a year whenever there is a commensurate increase in the Consumer Price Index. We object to this proposal even though it attempts to depoliticize the matter of benefit increases. The proposal is a one-way street. It does not provide for decreases in benefits if the cost-of-living drops. It relates to only one factor—albeit an important factor. That factor is different from the factor proposed for the automatic increase in taxable wage base and in the retirement earnings test. The possible dissimilar operation of the two different factors (cost-of-living and quarterly taxable wages) could distort both the benefit formula and the benefit-

wage relationship as well as the program financing. The distortion would not necessarily be equitable to either beneficiaries or taxpayers, and undoubtedly would require the continued program review and adjustment by the Congress.

The proposal would eliminate from consideration the underlying coverage, demographic, and economic factors necessary to determine the actual soundness of the program. It would also eliminate from consideration the general economic climate of the Nation as well as the overall burden on our taxpayers.

We do not think it possible to design an automatic formula to meet our objections or avoid the pitfalls mentioned above. We feel that there is no substitute for periodic congressional review of benefits and financing at the same time.

Revision of the benefit formula: A review of the historic changes in the formula for determining the primary insurance amount will show a continual and increasing advantage being given to beneficiaries in low earnings brackets. Moreover, as the taxable wage base and the scheduled tax rates have been increased over the years, and as is proposed in H.R. 14081, there has been a continual shift of the social security tax burden to beneficiaries in the higher earnings brackets. In other words, the greater portion of the tax cost of benefit improvements is borne by the latter, and their wage replacement upon retirement is smaller. We suggest this merits more attention of the Congress.

Increase in benefits for widows and widowers: Section 14 of H.R. 14081 proposes to increase the benefit for a widow or widower age 65 or more from 82½ percent to 100 percent of the primary insurance amount on which the benefit is based. It also proposes an actuarially reduced benefit for widows and widowers between ages 62 through 64—the reduction ranging downward to 82½ percent.

This proposal is substantial—it affects 2.7 million beneficiaries at a first-year cost of \$610 million. We oppose this proposal—not only because of the cost but because it provides a double barreled 33½ percent increase.

The increase from 82½ percent to 100 percent is a 21 percent increase. The further increase from 100 percent to 110 percent—representing the 10 percent general increase—is a further 12 percent increase in relation to the starting point, 82½ percent. Furthermore, we see no reason why a widow's or widower's benefit should occupy a preferred position in relation to any other dependent or survivor benefits. This proposal, if enacted, would set a precedent for later proposals for similar increases in benefits for mothers, children, surviving divorced wives, and parents.

Age 62 closing date for men: Section 9 of H.R. 14081 proposes to change the closing date in the primary insurance amount (PIA) computation to the year in which a man attains age 62. Currently, the closing date for a man is the year in which he attains age 65. However, the closing date for a woman already is the year in which she attains age 62. This latter provision was made in the 1960 amendments to the Social Security Act, and was recently held as constitutional and not discriminatory against men.¹ Regardless of the reasoning underlying the 1960 enactment or the judicial decision, we have never agreed with the principle that there should be an earlier closing date for women. Consequently, we oppose the current proposal.

¹ *Oskar Gruenwald v. John W. Gardner* (309 F. 2d 591).

Attached is exhibit I showing the difference in attainable monthly benefits that exist now and in the future. The difference is \$5 to \$6 per month until the year 2000. If the proposed 10 percent benefit increase is enacted now without section 9 being enacted, the difference will widen. On the other hand, if both sections 2 and 3 and section 9 are enacted, both men who have attained and will attain age 62 and their dependents will be entitled to a double increase in benefits. The Social Security Administration has testified that section 9 would affect 5 million current beneficiaries and 100,000 newly eligible beneficiaries—at a first-year annualized cost of \$392 million. This disregards the effect of any 10 percent or higher benefit increase.

Liberalization of the retirement earnings test: It has been the policy of the State chambers of commerce to support the periodic review and adjustment of the retirement earnings test in light of changing conditions.

We support that part of section 5 of H.R. 14081 that would increase the exempt earnings from \$1,680 per year to \$1,800 per year. The present law requires a reduction of \$1 in benefits for each \$2 of earnings between \$1,680 and \$2,880. Section 5 of H.R. 14081 would remove the limitation of \$2,880 and revoke the dollar-for-dollar offset against benefits of earnings above \$2,880.

We believe the principle underlying the proposal is sound as it would enable social security recipients to augment their retirement income more readily—a most laudable objective. It would also encourage rather than discourage the greater use of the skills and experience acquired by our senior citizens. It is common knowledge that older persons refrain from seeking employment and earnings that would jeopardize their social security benefits.

We are aware that the HEW estimate for the proposed modification of the retirement test indicates a first full calendar year cost of \$350 million. It is our understanding, however, that a complete elimination of the retirement earnings offset would cost about \$2 billion a year. This was an estimate made several years ago—undoubtedly it is higher now. It would see, therefore, that a 50-percent earnings offset without limitation could cost more than \$1 billion a year. We therefore suggest as an alternative that the present limit of \$2,880 be raised to \$3,000. This would be consistent with the past history and pattern of changes in the retirement earnings offset provision.

We particularly object to that portion of section 5 of H.R. 14081 which provides for an automatic increase in the retirement earnings test. Our objection is based on the same reasons as our objection to automatic increases in the taxable wage base after 1974 as provided in section 7 of H.R. 14081. We shall return to the proposals for automatic increases later.

Social security financing: Initially, we wish to state our general views on social security financing. We support periodic congressional reexamination of the situation: we believe that tax rates and the wage base need to be considered in light of current and short-term benefit costs—not in relation to changes in wage levels; we believe in limiting the accumulation in the OASI and DI trust funds, and we believe in meeting higher benefit costs primarily by raising tax rates rather than the taxable wage base. Finally, we strongly oppose an automatic increase in the taxable wage base.

(a) Automatic increase in the taxable wage base: Section 7 of H.R. 14081 proposes an innovation—to increase (but not to decrease) the taxable wage base above \$9,000 after 1972 according to the ratio of taxable wages in the first quarter of even-numbered years to taxable wages in the first quarter of 1972, the increase being to the nearest \$600 multiple.

Our objection to this innovation is not based only on the elements or structure of the formula—the use of quarterly payrolls and a biennial period. The formula could reflect not only rising wage levels, but also expanded coverage—which has no logical relationship to taxable wage limits. The way we read the draft language of section 7, the taxable wage base could only be raised—not lowered. The formula could produce excessive and useless funding in periods of rapidly rising wage levels. This could continue after wage levels became more stable. It would be necessary at that point for the Congress either to revise the benefit formula upward (despite the dissimilar operation of the cost-of-living index for benefits) to prevent an embarrassing accumulation of trust funds, or to adjust the formula itself.

If Congress does not enact the automatic cost-of-living increase provision contained in section 4, there is no need to enact section 7—the automatic increase in the taxable wage base. We feel that tax rates and wage bases need to be considered in light of benefit demands and not only in relation to wage levels. In any event, we can see no way that the Congress can divorce its necessary attention to and concern for the program by adopting automatic escalators in benefits, wage base, and retirement earnings offset.

(b) The \$9,000 taxable wage base in 1972: Section 6 of H.R. 14081 proposes a \$1,200 increase in the taxable wage base in 1972. Section 8 of H.R. 14081, which should be considered together with section 6, proposes to lower tax rates during 1971–76 and to shift more tax revenue from the OASDI trust fund to the Hospital Insurance Trust Fund during 1971–86.

When Congress was considering the 1967 Social Security Act amendments contained in H.R. 12080, we stated our opposition to increasing the taxable wage base from \$6,600 to \$7,800. We stated that official HEW estimates indicated that H.R. 12080 which provided a 13 percent general increase in benefits also would have raised \$22 billion excess social security taxes during the period 1968–72 primarily because of the increased wage base. We have checked these estimates with the data² included in the 1969 council report of the trustees of the OASDI trust fund. The estimates were borne out—the 1968–72 excess social security tax collections are expected to be \$21.7 billion. But it is interesting to note that the trustees in 1969 estimated substantially higher taxes and benefits in 1971 and 1972. Conversely, the 1967 official HEW estimates anticipated substantially lower taxes and benefits in 1971 and 1972. (See exhibit II.)

Similarly, we have compared the 1970–1973 estimates in the Trustees' 1969 annual report with the HEW estimates concerning the administration proposal.³ The HEW estimates are attached in exhibit III. These HEW estimates which have been submitted to this committee show with respect to comparisons under the present law a substantial variation from the trustees' report (see exhibit IV).

² Tables 13 and 17, pp. 49 and 45, respectively.

³ Social security charts—table 20, October 1969.

The HEW estimates that the present law will increase excess social security tax collections by \$15.4 billion more than estimated in the trustees' 1969 report. This would bring the excess to \$43.4 billion for the 4-year period. This occurs because of \$7.8 billion higher taxes and \$7.6 billion lower benefits estimates. We suggest that these variations in table 20 of the HEW social security charts are too substantial to be disregarded.

Table 20 indicates that the administration proposal would cause a reduction of \$22.7 billion in excess tax collections for OASDI purposes—something which we would otherwise espouse. Most of this reduction is caused by tax rate reductions, despite the taxable wage base increase in 1972, but there is also a shift of tax revenues of \$6.2 billion to the Hospital Insurance Trust Fund.

We are concerned about the past overtaxation of the social security program and we are more concerned because this overtaxation will continue and increase over the next 4 years. If the present law remains unchanged, the overtaxation will be between \$28 to \$44 billion. If the administration proposal is enacted, the overtaxation will be \$20.7 billion—according to the HEW estimates.

A further glance at table 20 shows 1970–1973 income under the present law of \$164.3 billion and 1970–1973 benefit and expense costs under the administration proposals to be \$133.9 billion. Thus, there is a patent \$30.4 billion overtaxation in this short period—even if the financing were to remain unchanged! We ask how this can be justified at a time when the termination of the Federal income tax surcharge is in doubt and when the Congress is considering Federal individual income tax reductions in 1971 and 1972 in the tax reform bill, H.R. 13270!

We submit that there is no justification whatsoever for deciding at this time to raise the taxable wage base to \$9,000 in 1972.

(c) Change in tax rates: H.R. 14081 proposes to reduce the combined employer-employee OASDI tax rate as follows:

TAX RATES
In percent

	From	To	Difference
1971-2.....	9.2	8.4	-0.8
1973-4.....	10.0	8.4	-1.6
1975-6.....	10.0	9.2	-.8
1977-9.....	10.0	9.6	-.4
1980-86.....	10.0	9.8	-.2

H.R. 14081 also proposes to increase the combined employer-employee HI tax rates by 0.6 percent for 1971–72; 0.5 percent for 1973–75; 0.4 percent for 1976–79; and 0.2 percent for 1980–86.

The combined effect, therefore, is a reduction in the total tax rates for the years 1971–76. We have attached exhibit V which shows on a peremployee basis the effect of proposed lower tax rates and the higher wage base at various levels of annual earnings. There is a significant increase in the tax reduction as earnings increase to \$7,800, and a significant tax increase for earnings of \$9,000 or more. We are certain that this proposed shift of tax from those earning less than \$7,800 to those earning \$9,000 or more is not widely known or envisioned by the latter group. When and if this becomes common knowledge, and it is

weighed in connection with the "tax reform" proposals for low income allowances and income tax reductions for low income taxpayers, we suggest this may give new emphasis to a "tax rebellion" among the middle income employees and self-employed persons.

Concluding remarks on social security amendments: It will serve no purpose to dwell at length upon other points we raised 2 years ago in connection with the 1967 social security proposals. Then, we cautioned against:

The overburdening of the younger people with social security taxes;
 Making the social security program less popular among the younger people who might otherwise find it more advantageous to accumulate a greater retirement benefit through private annuities rather than through the payment of taxes;

Endangering private pension plans by overliberalizing the social security program and making it too costly;

Ignoring the impact of State and local taxation;

Concluding that employer social security tax costs are insignificant or that the employer paying higher wages is better able to and should bear the major portion of increases of such costs.

We think these general cautions are still cogent. We urge that you give them, and the other more specific points we have raised, serious consideration.

Annual social security wage reporting: We wish to suggest a new avenue of investigation by the Ways and Means Committee and its staff. Because of the increased use and efficiency of computers for recording bulk data, we believe the annual rather than quarterly reporting of social security taxable wage data for each employee would promote a substantial savings to both the Government and employers.

At one time an estimate of possible savings was in the neighborhood of \$40 million a year. It is virtually impossible, however, to determine a precise cost savings.

The Council of State Chambers of Commerce has had meetings with Social Security Administration officials on this suggestion, and we understand that that agency is studying the matter with renewed interest and objectivity. The council has conducted an extensive survey among employers and found that there was substantial interest from both large and small employers for this change. Further, the Senate Subcommittee for Small Business has reported that this matter should be given favorable consideration.

We concur with the Social Security Administration's position that the use of a copy of the annual "Wage and Tax Statement," form W-2, by the Social Security Administration is not the solution. This would mean that the agency would have to handle some 90 million separate pieces of paper annually instead of the present quarterly 941a forms which list 25 employees per page.

We have often wondered, however, why it is necessary to give an employee a duplicate copy of the official form W-2 for its use by the Internal Revenue is rather limited. First, the social security wage and tax withholding information is of interest to the internal revenue service only where an employee claims excess social security tax deductions and the refund thereof. It is our understanding that the Federal income tax wage and tax data as shown on the original form W-2 are stored in a master computer as to each individual taxpayer's

account; but these data which are included on the copy of the form W-2, which is attached to the individual tax return, form 1040, are used only to verify the information shown on that return. We suggest that copy of the form W-2 could be eliminated.

It is possible that the "quarters of coverage" concept in the Social Security Act could be and should be eliminated. Such an elimination would make annual wage reporting more feasible.

We feel the matter of annual social security wage reporting would not disturb the present system of depositing and remitting social security taxes on a quarterly basis.

H.R. 14173—Family assistance plan: Public assistance payments for welfare at all levels of Government currently approach an annualized rate of over \$11 billion. As of May this year, the annualized rate for cash benefits was \$6.4 billion; and for medical vendor payments, it was \$4.7 billion (see exhibit VI). This does not take into consideration the values of the food stamp program and surplus food distributions to the needy.

H.R. 14173 proposes to add \$1.4 billion as a first full-year cost of a new program. An October 27 dispatch in the New York Post indicates that a yet unreleased administration survey has raised the administration's original estimate of the number of working poor by 25 percent. The future annual costs of this new program, and those under any State supplemental programs, are indeterminable but probably astronomical. We need only refer to a 1967 tax foundation study⁴ which concludes that the median growth in Federal program costs is 526 percent in 6 years.

Despite the current rate of spending for public aid, the entire effort has been roundly censured on one hand as being woefully insufficient and demeaning; and on the other hand, as too costly and loosely controlled. The U.S. Supreme Court has stricken the "man in the house" and the "1-year residency" rules—rules which States had adopted as reasonable prohibitions. Fraud and abuse have been rationalized by welfare agency officials but have aroused taxpayers. The 100 percent offset of earnings against assistance payments has been tortured into the concept of a tax to justify the allegation that the offset is discriminatory in contrast to progressive income taxation.

The system has been charged with promoting indolence and bastardy. There are forces trying to persuade the public that the right to public aid and guaranteed income are constitutional rights. Welfare recipients are organizing, demonstrating—in some instances beyond legal limits—and are not beyond threatening riots in order to obtain more money.

With this background of increasing polarized views, trade and business associations have developed opinions and policies with respect to public welfare. The policy recommendations of the Council of State Chambers of Commerce Social Security Committee, for example, embody the following views:

The mere unplanned expenditure of additional money will not in itself reduce poverty.

The reduction in poverty requires the long-term efforts of all segments of our society and the financing of programs should be shared by all levels of Government—Federal, State and local.

⁴ "Growth trends of new Federal programs—1959-66," Tax Foundation, Inc.

Efforts should be concentrated primarily on the "poor." Education, job training, and employment programs should be made available to both the "poor" and the "near poor."

There should be a rehabilitation program for able-bodied adults without preschool children and with a work potential. There should be an incentive allowance for such adults who take needed training and such training should be mandatory. There should be an economic incentive to work and a requirement to accept suitable work—and "suitable work" should not be left to the discretion of the welfare recipient.

The link between income and work should not be broken. "Income assurance without work" would result in a serious loss of incentive for work and would promote an antipathy toward welfare recipients among all taxpayers.

National programs of income maintenance (such as guaranteed income, universal family or children allowances, or negative income tax) financed by the Federal Government are incompatible with the welfare program based on a need and rehabilitation.

To allow for regional and State differentials and for special conditions within any State, no Federal minimum standards for such assistance should be imposed.

We have examined H.R. 14173 in light of the council's policy recommendations to the State Chambers of Commerce. We can support in principle some parts of H.R. 14173, but we are not ready to endorse the proposed family assistance plan. Rather we believe further efforts for reform of the welfare system within the Federal-State framework should be made before Congress undertakes what Secretary Finch has accurately described as "revolutionary structural reforms."

We can sympathize with Governors whose chances for reelection would improve if they could avoid State tax increases to finance unpopular welfare programs—but State Chambers of Commerce believe that a completely Federal program would not be in the best interests of the Federal-State system. In fact, the experience of State Chambers of Commerce indicates that States could do a better job of combating basic abuses if some of the present Federal restrictions were removed—instead of imposing new controls as would H.R. 14173. We also feel that the Government should have a more adequate program for the nonworking poor before moving into the largely unknown with a cash program for the working poor.

Support in principle for some provisions of H.R. 14173: We subscribe to the objectives of a number of the provisions of H.R. 14173 which we feel move in the proper direction of strengthening the Federal-State welfare system—not "revolutionary" restructuring. Proposals that we support in principle include:

1. Registration for work and training—that would be required for eligible family members unless in an excepted group. This builds upon the work and training provisions in the 1967 social security amendments which we supported. We would add a word of caution on one aspect with which we have had considerable experience in connection with unemployment benefits—that is refusal without good cause to accept suitable employment. It would seem that it would not be appropriate for suitability of a potential job for a welfare recipient to be defined as narrowly as is generally the case for an unemployment benefit claimant.

2. Training allowances—the proposed allowances of \$30 a month plus transportation and other expense allowances would not seem to be excessive. We think this would be feasible.

3. Child care and support services—great expansion is needed in this area if the work and training programs are to be made available for many AFDC mothers.

4. Liberalized Federal payments to States—States should be encouraged to bring benefits up to their own standards of need. The present categorical aid programs involve Federal, State and local cost sharing. It would seem that as an alternative to the Federal benefit payable under the family assistance system the Federal contribution formula used under the present programs could be increased in many different ways. The limit to such variations would be only the amount of Federal appropriations that Congress wishes to authorize.

5. Retention of a greater proportion of earnings by beneficiaries—this is desirable to provide greater incentives for self-support. But, as was demonstrated in the 1967 social security amendments provision on the earnings exemption for the AFDC program, it is not necessary to abolish present programs and substitute a revolutionary family assistance plan to do this.

We disagree with the idea that the first \$720 of annual earnings should be disregarded in offsetting earnings against assistance payments. The underlying theory for this is that this amount represents the commuting, food, and miscellaneous expense connected with the job. This is a special advantage available to no other person who receives public funds while working—this provision is not found in unemployment insurance, temporary disability, and workmen's compensation insurance, or in social security programs. The rationale for the proposal is weak. Proponents who argue that the earnings offset is a tax, overlook the fact that commuting, food, and miscellaneous expense connected with the job are not deductible for tax purposes by our taxpayers.

We agree with the proposal to reduce the percentage of the earnings offset from 100 percent to 50 percent, and we agree that 50 percent of unearned income should also be so offset against welfare payments. The reduction in the offset of such income should increase the incentive to work. We would point out, however, that this is not necessarily an exclusive facet of a family assistance system. The principle can be applied in any form of public welfare assistance programs including the current program.

The work-training programs also can be made more meaningful by giving greater financial incentives to the States to participate in the unemployed parents program in connection with AFDC. By making benefits available to unemployed fathers one of the major weaknesses of the present welfare system to which the President referred in his August 11 message can be corrected. That is the fostering of family breakup that results from regulations in some States, that do not participate in AFDC-UP, which have the practical effect of making the father live out of the home before aid will be given. If the father is encouraged to remain at home and required to register for the work-training program, a dual purpose will be served.

Opposition to provisions in H.R. 14173: In addition to not supporting the proposed family assistance plan there are several provisions

in H.R. 14173 which we feel are not in the best interests of the Federal-State system and the insurance aspects of our social security programs. We refer specifically to:

1. The imposition of Federal minimum standards—the States should be encouraged to meet their own standards of need, but we doubt that it is desirable to impose a uniform \$90 minimum. This does not allow sufficiently for regional and State differences and for special conditions within States.

We disagree with the proposal to establish a Federal minimum benefit standard which does not take into consideration State, regional, or local variations in costs of living. We are aware, however, that the constitutionality of variations in welfare payments within a State is being tested in Federal courts. To those who argue that a Federal benefit cannot be varied on a State-by-State basis, we would point to the precedent under the 1962 TEUC Act (Temporary Extended Unemployment Compensation Act), wherein Federal-paid extended UC benefits were continued after a claimant had exhausted his State benefits which varied by claimant and by State.

Moreover, we disagree with the concept of a national benefit standard despite the fact that it is supported in some richer industrial States as an indirect means to stem the immigration of welfare recipients from the less affluent States. We believe the States and the larger cities have the responsibility of keeping their welfare payments in line—some States should increase their payments and some should reduce them. The proposal seduces the States from that responsibility by providing a higher level of welfare payments in the poorer States. This would create in these States the same problem that now exists in some of the large industrial cities—welfare is more attractive than work.

2. The prohibition in section 1603 against lien and recovery and family responsibility laws—This is a matter that should be left to the determination of each State depending upon the attitude of the people of the State. There are still States where the public strongly believes that adult children who are able to contribute to the financial support of their aged parents should be legally required to do so. These same States tend also to see only simple justice if after an adult child has failed to provide adequate financial support for his aged parents, the State reduces his inheritance through a lien and recovery law.⁵ Generally, State chambers of commerce have supported State family responsibility and recovery laws.

3. Administration of "welfare" programs by the Social Security Administration—H.R. 14173 generally delegates authority to the Secretary of Health, Education, and Welfare without specifying sections within the Department of HEW, but Secretary Finch's explanation of the bill contains the following statement that causes concern in several respects:

⁵ According to the HEW *Public Assistance Report No. 50* on "Characteristics of State Public Assistance Plans" as of Dec. 31, 1967, the following 33 jurisdictions have some form of lien and/or recovery provisions for one or more public assistance programs: Alaska, Colorado, Connecticut, District of Columbia, Florida, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Maine, Maryland, Massachusetts, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Utah, Vermont, Virginia, Wisconsin, and Wyoming.

States will be given the option, for both the supplementary payment and the adult category programs, to contract with the Social Security Administration for Federal assumption of some or all of the Administrative burdens under these programs.

This quote concerns us not only because it indicates that Federal administration of all or most welfare programs would be possible under this bill, but also because it indicates that the administration is still looking favorably on the Social Security Administration as the proper agency within HEW to administer welfare. Administration of "welfare" programs by the Social Security Administration could contribute to the further erosion of the "insurance" aspects of our "social insurance" system.

The President said in his August 11 message that the Social Security Administration operation of the new program, ". . . of course, will be entirely separate from the social security trust fund." This is not entirely reassuring, however. No doubt top Social Security Administration officials will be concerned with both the new program and the older "social insurance" system and very likely so will many technical experts on down the line. Even if this were not the case, by having the Social Security Administration operate a sizable "non-insurance" type of program, it may tend to undermine the "social insurance" programs that presently are its primary responsibility. While present Federal aspects of public assistance are handled by HEW and the Social Security Administration is part of HEW, public assistance in recent years has been the primary responsibility of the Welfare Administration (now the Social and Rehabilitation Service), not the Social Security Administration.

Even though Federal aspects of public assistance were at one time administered by a bureau within the Social Security Administration, the operation of the public assistance program primarily is a State function whereas the proposed family assistance plan would be largely federally administered. The State chambers of commerce support continued State administration of welfare programs.

"Welfare" programs should continue to be based on "need": It would be most unfortunate if administration of "welfare" programs by the Social Security Administration should lead to a weakening of the public confidence in the social "insurance" programs administered by SSA. It is important to maintaining this confidence that a sharp distinction be maintained between "welfare" programs based on "need" and "social insurance" programs to which beneficiaries and their employers have contributed and under which benefits are available as a matter of "right." If both types of programs are administered by the same agency it will be more difficult to maintain this distinction. We believe that welfare programs based on "need" are properly administered at the State and local level with assistance and encouragement, but not control, from the Federal Government.

We support use of declarations relating to financial resources in connection with aid programs for the needy aged, blind, and disabled. We object, however, to the use of simple declarations in connection with AFDC or family assistance programs.

If it is contended that all welfare should be available as a matter of "right" upon application, this could well lead to a corrupting and weakening of our basic "social insurance" principles. Congress should exercise great care to make certain that while attempting to help an

increasingly small portion of our population, it does not endanger the social security programs that benefit our public generally.

Implications for budget control: Both those in Congress and the Executive branch that are concerned with controlling rapidly increasing Federal spending have found that a major problem is the large proportion of the Federal Budget that is "relatively uncontrollable."⁶ The 1970 Budget document shows \$98.8 billion for "relatively uncontrollable civilian programs" versus \$20.6 billion of "relatively controllable civilian programs." As recently as 1967 the proportion was \$57.1 billion uncontrollable versus \$35.2 billion controllable.

The administration social security and welfare proposals would further compound the problem in that most of the costs would be "relatively uncontrollable," that is, an additional \$4.4 billion a year each for the social security and welfare proposals or a total of \$8.8 billion.

If to this were to be added the \$5 billion the administration proposes for revenue sharing by 1976 the problem becomes still greater. If the concepts of family assistance and revenue sharing are adopted, the amounts suggested by the administration seem likely to be no more than a beginning.

The following State chambers of commerce have endorsed this statement:

Alabama State Chamber of Commerce*
 Colorado Association of Commerce & Industry
 Connecticut State Chamber of Commerce, Inc.
 Delaware State Chamber of Commerce, Inc.
 Florida State Chamber of Commerce
 Georgia Chamber of Commerce
 Idaho State Chamber of Commerce
 Indiana State Chamber of Commerce
 Kansas State Chamber of Commerce*
 Kentucky Chamber of Commerce
 Maine State Chamber of Commerce
 Michigan State Chamber of Commerce
 Montana Chamber of Commerce
 New Jersey State Chamber of Commerce
 Empire State Chamber of Commerce
 Ohio Chamber of Commerce
 Pennsylvania State Chamber of Commerce
 South Carolina State Chamber of Commerce
 East Texas Chamber of Commerce
 South Texas Chamber of Commerce

⁶ See Eugene F. Rinta, "The Federal Budget and Expenditure Control," *The Annals*, vol. 379, September 1968, pp. 24-30 for a more complete discussion of this problem. The fiscal 1970 and 1969 budget documents, pp. 16 and 15, give the following breakdown of estimated budget outlays:

[In billions]

	1970	1967
National defense.....	\$81.5	\$70.1
Relatively uncontrollable civilian programs.....	98.8	57.1
Relatively controllable civilian programs.....	20.6	35.2
Total.....	200.9	162.4
Less undistributed intergovernmental payments.....	-5.7	-4.0
Total.....	195.3	158.4

*See footnote on p. 1742.

West Texas Chamber of Commerce
 Lower Rio Grande Valley Chamber of Commerce
 Virginia State Chamber of Commerce
 West Virginia Chamber of Commerce
 Wisconsin State Chamber of Commerce
 Greater South Dakota Association.*

We sympathize with the role of the Ways and Means Committee which is charged with the responsibility of insuring the necessary tax revenues and urge the committee to use its resolute restraint in deciding the limits of taxes and benefits in both of these important measures.

Thank you.

(The exhibits referred to follow:)

EXHIBIT I.—BENEFITS PAYABLE UNDER THE 1967 AMENDMENTS TO A WORKER RETIRING AT AGE 65 WITH
 MAXIMUM CREDITABLE EARNINGS

Year of attainment at age 65 ¹	Benefit		Year of attainment at age 65	Benefit	
	Man	Women		Man	Women
1968 ²	² \$156.00	² \$161.60	1980.....	\$185.40	\$192.00
1969.....	160.50	167.30	1981.....	186.50	193.00
1970.....	165.00	170.70	1982.....	187.60	194.00
1971.....	168.40	174.10	1983.....	188.80	195.00
1972.....	170.70	177.50	1984.....	188.80	196.00
1973.....	172.90	179.70	1985.....	189.90	197.00
1974.....	175.20	182.00	1990.....	194.00	200.00
1975.....	177.50	184.20	1995.....	199.00	204.00
1976.....	179.70	186.50	2000.....	209.00	214.00
1977.....	180.80	187.60	2005.....	217.00	218.00
1978.....	182.00	188.80	2006.....	218.00	218.00
1979.....	184.20	189.90			

¹ Assumes retirement at beginning of year.

² 1968 amounts payable beginning February 1968.

EXHIBIT II. ESTIMATED—OASDI PROGRESS—PRESENT LAW

[In billions of dollars]

	Taxes		Benefits and expense		Difference	
	1967 HEW estimate	1969 trustee report	1967 HEW estimate	1969 trustee report	1967 HEW estimate	1969 trustee report
Fiscal year:						
1968.....	\$27.5	\$27.0	\$26.1	\$25.4	+\$1.4	+\$1.6
1969.....	30.8	32.0	27.2	27.3	+3.6	+4.7
1970.....	32.1	33.8	28.2	29.8	+3.9	+4.0
1971.....	35.8	38.1	29.3	32.8	+6.5	+5.3
1972.....	37.3	39.9	30.6	33.8	+6.7	+6.1
Total.....	163.5	170.8	141.4	149.1	+22.1	+21.7

*Endorses only the Social Security portions of the statement.

EXHIBIT III

TABLE 20.—ESTIMATED PROGRESS OF THE CASH-BENEFITS TRUST FUNDS UNDER PRESENT LAW AND UNDER PROPOSAL, 1970-73

[In billions of dollars]

Fiscal year	Income		Outgo		Net increase in funds	
	Present law	Proposal	Present law	Proposal ¹	Present law	Proposal
1970.....	35.2	35.2	28.4	29.1	6.8	6.1
1971.....	38.6	36.8	29.6	32.9	8.9	3.9
1972.....	43.1	39.3	30.8	35.4	12.3	3.9
1973.....	47.4	43.4	32.0	36.5	15.4	6.8
Total.....	164.3	154.7	120.8	133.9	43.4	20.7

¹ Assumes no automatic increases in benefits under the cost-of-living provision.EXHIBIT IV.—OASDI PROGRESS—PRESENT LAW ¹

[In billions of dollars]

Fiscal year:	Taxes		Benefits and expense		Difference	
	1969 trustee report	HEW estimate	1969 trustee report	HEW estimate	1969 trustee report	HEW estimate
1970.....	33.8	35.2	29.8	28.4	+4.0	+6.8
1971.....	38.1	38.6	32.8	29.6	+5.3	+8.9
1972.....	39.9	43.1	33.8	30.8	+6.1	+12.3
1973.....	44.7	47.4	32.0	32.0	+12.7	+15.4
Total.....	156.5	164.3	128.4	120.8	28.1	43.4
	+7.8		-7.6		+15.4	

¹ Totals may not agree due to rounding of figures.EXHIBIT V—HOW H.R. 14081 SHIFTS THE ANNUAL COMBINED OASDI AND HI TAXES PER EMPLOYEE FROM LOW-WAGE TO HIGH-WAGE EMPLOYEES ¹

Annual earnings	1971	1972	1973	1975	1976	1977	1980	1987
\$2,000.....	-\$2.00	-\$2.00	-\$11.00	-\$3.00	-\$4.00	-----	-----	-----
\$3,000.....	-3.00	-3.00	-16.50	-4.50	-6.00	-----	-----	-----
\$4,000.....	-4.00	-4.00	-22.00	-6.00	-8.00	-----	-----	-----
\$5,000.....	-5.00	-5.00	-27.50	-7.50	-10.00	-----	-----	-----
\$6,000.....	-6.00	-6.00	-33.00	-9.00	-12.00	-----	-----	-----
\$7,000.....	-7.00	-7.00	-38.50	-10.50	-14.00	-----	-----	-----
\$7,800.....	-7.80	-7.80	-42.90	-11.70	-15.60	-----	-----	-----
\$9,000 and over.....	-7.80	+53.40	+18.30	+54.30	+50.40	+68.40	+69.60	+70.80

¹ Assuming a static \$9,000 taxable wage base after 1971. The minus figures do not indicate an absolute tax cut, but rather a reduction of the tax increases provided for in the present law.

EXHIBIT VI.—PUBLIC WELFARE EXPENDITURES ¹ (MONTHLY AND ANNUALIZED)

Program	Numbers (in thousands)	Average monthly benefit, May 1969	Monthly dollar expenditure (in millions)
Old-age assistance.....	2,034	\$70.60	\$143.6
Aid to blind.....	80	94.85	7.6
Aid to permanently disabled.....	747	85.60	64.0
Aid to families with dependent children.....	6,547	43.10	282.2
General assistance.....	799	47.45	37.9
Cash benefits.....			534.3
Medical vendor payments.....			387.5
Total.....			921.8
Annualized amounts:			
Cash benefits.....			\$6,412,000,000
Medical vendor payments.....			4,650,000,000
Total.....			11,062,000,000

¹ Source; Tables M23-25, Social Security Bulletin, September 1969.

Mr. FULTON. Thank you, Mr. Henkel.

Do you have a statement, Mr. Brown?

Mr. BROWN. No, Mr. Henkel made the statement for us.

Mr. HENKEL. Before closing, may I add a personal note.

We wish to commend the Ways and Means Committee for its final decisions in connection with H.R. 12625, the Federal unemployment tax revisions. Those decisions were announced last week. We recognize there were many hard decisions involved and many conflicting views to be resolved and the end result is a far less harmful bill to business and industry than was the original proposal.

Mr. FULTON. Thank you, Mr. Henkel.

Are there any questions?

Mr. Schneebeli.

Mr. SCHNEEBELI. Mr. Henkel, it is quite obvious that you and your committee have given a lot of study and gone into this matter in great depth, and, while I have not analyzed all your specific recommendations, we appreciate very much the study that you have given to this, and we will look into this further. Thank you very much for your very comprehensive observations.

Mr. HENKEL. Thank you, sir.

Mr. FULTON. Do you have questions, Mr. Corman?

Mr. CORMAN. Thank you, Mr. Chairman.

Mr. Henkel, I noticed that you are apprehensive about Federal standards, particularly the one setting a minimum of \$90 a month for an aged person.

Is there some place in the country that that is more than is necessary to provide a living for a senior citizen?

Mr. HENKEL. I could not say. I cannot be sure that that would be so in connection with any of the benefits under the categorical aid programs.

Mr. CORMAN. But you still object to a Federal standard, a requirement that it be at that level?

Mr. HENKEL. Yes, sir.

Mr. CORMAN. I just wondered if that was because that was more than was needed some place, and, if true, where that place was.

Mr. HENKEL. No, we could not say that, sir.

Mr. CORMAN. Thank you.

Mr. FULTON. Do you have questions, Mr. Bush?

Mr. BUSH. No, thank you, Mr. Chairman.

Mr. FULTON. Mr. Henkel, we certainly want to express our appreciation to you and Mr. Brown for your appearance, and the contribution that you have made to us for our deliberations, and amendments to the Social Security Act, hopefully in 1969.

Mr. HENKEL. Thank you.

Mr. FULTON. Our next witness will be Mr. Leonard Lesser, Secretary-Treasurer of the Committee for Community Affairs.

Mr. Lesser, on behalf of the committee, we welcome you here today, and, if you would identify yourself, you may proceed with your testimony, sir.

STATEMENT OF LEONARD LESSER, SECRETARY-TREASURER, COMMITTEE FOR COMMUNITY AFFAIRS; ACCOMPANIED BY JACK BEIDLER, EXECUTIVE DIRECTOR

Mr. LESSER. Thank you, Mr. Chairman.

My name is Leonard Lesser, and I am Secretary-Treasurer of the Committee for Community Affairs.

I am accompanied by Jack Beidler, who is executive director of the committee.

Mr. Chairman, you have a copy of my statement. With your permission, I would like to submit it and ask that it be printed in the record, and I would like to talk from it and about it without reading it.

Mr. FULTON. Without objection, it will be printed in the record, and we welcome your comments now, sir.

(The statement referred to follows:)

PREPARED STATEMENT OF LEONARD LESSER, SECRETARY-TREASURER, COMMITTEE FOR COMMUNITY AFFAIRS

My name is Leonard Lesser. I am Secretary-Treasurer of the Committee for Community Affairs.

This statement is submitted on behalf of CCA, a nonprofit corporation organized among other things to represent and speak for community organizations of the poor and disadvantaged. In such role the Committee is primarily concerned with legislative proposals aimed at providing adequate income to the poor.

When one thinks of income for the poor one generally thinks of the cash assistance titles of the Social Security Act (Titles I, IV, X, and XVI). But one cannot express concern about the poverty of the aged without expressing concern about the inadequacies of the Old Age, Survivors and Disability Insurance benefits provided under Title II of the Social Security Act.

To the extent that the old age insurance benefits are so low that millions of aged who depend on them live in poverty, assistance programs for the aged are saddled with a greater burden. More attention is focused on the need to improve the level of assistance benefits and more concern is expressed about the cost of the assistance program.

On the other hand, to the extent that Social Security benefits are raised to assure a decent standard of living, then the cost of old age assistance, even with improvements in its benefits, can be kept within reasonable levels.

Similarly, while concern is expressed about the increased numbers of beneficiaries under the Medicaid provisions of Title XIX, dependence on this program by the aged results from the gaps in protection under the Medicare insurance provisions of Title XVIII.

Because of these relationships this Committee is to be commended for scheduling hearings covering all titles of the Social Security Act. It, too, is aware that

one cannot discuss improvements in Social Security benefits without recognizing the implications for old age assistance, the reduction in the number of assistance recipients and the savings in assistance costs. Since the single goal of Titles I, II, XVIII, and XIX are security for the aged, they must be considered together.

At the same time, in considering proposals similar to those embodied in HR 14173 which are aimed at providing cash assistance to other than the aged, blind or disabled, one must recognize the relationship between such proposals and the whole range of federal programs aimed at assuring an adequate standard of living for American families. To the extent that one program—welfare reform, a family assistance plan, or a negative income tax—is expected to assure everyone an adequate income, that program must be saddled with such enormous costs as to doom it to failure. The Economic Report of the President (January, 1969) has pointed out that for an annual expenditure of \$9.7 billion all poor persons and families could be lifted above the poverty income level.

Just as old age assistance should not be blamed for the inadequacy of our Social Security system, neither should a welfare program, whatever its form, be denounced because there are not enough jobs for people. Too many jobs are not covered by the minimum wage or the minimum wage is so low that even persons who receive it and work full time still are forced to live in poverty.

The enactment of increases in the minimum wage or programs to provide jobs are beyond the jurisdiction of this Committee. Yet the Committee, in considering proposals to supplement the income of those who are without jobs or who are working full time but whose wage income is less than adequate, has the jurisdiction and the obligation to recommend measures which will preclude such proposals from keeping people in substandard jobs. It must also recognize that the costs involved in providing assistance to such families are not at a fault of the family assistance plan but are occasioned by the failure of employers to pay decent wages.

While the income of the working poor should be supplemented through the family assistance program, we should be aware that such supplementation does not remove the need for an adequate minimum wage covering all jobs. An increase in the minimum wage, extension of its coverage, the creation of jobs, and improved social insurance programs to provide adequate income during periods of unemployment, sickness and old age will prevent poverty before it occurs. With such measures, the burden left to the welfare program will be those relatively few persons who have unusual needs or for unusual reasons fall outside the scope of the basic programs. Reduction in welfare rolls should flow from jobs and wages, not from restrictive, punitive or budget cutting measures.

With these considerations in mind, let us examine the proposals before this Committee for improvements in the benefits provided under the various titles of the Social Security Act.

SOCIAL SECURITY BENEFITS

By any reasonable standard Social Security benefits are shockingly low. Current law provides a minimum benefit of \$55 a month or an annual income of \$660 for an individual and \$990 for an aged couple. Compared to \$2,900, the amount which the United States Bureau of Labor Statistics has found necessary for an aged couple to live at a "low" level, its inadequacy is apparent—\$1,910. Even the aged couple who is receiving the average monthly Social Security benefits of \$168 is still forced to live with an annual income of \$884 below the level needed for minimal decency. Is it any wonder than 20% to 25% of Americans living in poverty are above the age of 65?

HR 14080, the Administration bill, proposes to meet this problem by increasing current benefit levels by 10% with a new minimum of \$61 a month. The proposed annual increase in the minimum of \$72 for an aged individual and \$108 for an aged couple hardly moves toward meeting the deficiency of \$1,910 which now exists between minimum benefits for an aged couple and their required budgetary needs.

The inadequacy in the minimum proposed in HR 14080 is highlighted by the provisions of HR 14173 also proposed by the Administration which recommends a minimum of \$90 a month for the aged, blind, or disabled welfare recipient and \$180 a month or \$2,160 a year for the couple on welfare.

Why shouldn't our Social Security system, the most widely accepted program which has been established in the last 35 years, not provide at least the minimum benefits proposed under our welfare program? Why should beneficiaries of Social Security who have contributed during their entire working life be required to

turn to an assistance program—largely financed from the Federal Treasury—to be assured of an adequate income?

We would strongly urge that the minimum benefits provided under Title II be increased so that all persons receiving Social Security benefits be assured of an income at least sufficient to permit him to live above the poverty level. As an immediate step we recommend that the minimum be increased to \$100 a month.

We also believe that a general benefit increase substantially in excess of the 10% proposed in HR 14080 is essential if the Social Security system is to achieve its goal of providing benefits which are reasonably related to the wages earned during the working year.

An increase of 10% would do little more than match the increase in the cost of living since February, 1968, the date of last benefit increase. It does nothing to permit Social Security beneficiaries to participate in the real growth of the American economy.

There are other improvements in our Social Security system which have been suggested. Of these I would like to mention two which would be of particular value to the aged whose income needs are the greatest.

The first which is proposed in HR 14080 would increase the benefits payable to a widow from 82½% of her spouse's primary benefit to 100%. This amendment is long overdue. The needs of a widow are no less than the needs of any other aged individual. I would only suggest that the increase be made effective for widows who go on the rolls at age 62 as well as those who first go on the benefit rolls at age 65. There is no logic in giving any widow a benefit which is less than the primary benefit to which her husband would have been entitled.

The second proposal which unfortunately is not contained in HR 14080 would permit the receipt of full benefits at age 60 or 62 by individuals who through no fault of their own have been effectively cut off from the labor market by changes in technology or the economic environment of the communities in which they live. The worker, age 60, who is located in Appalachia where the mine, which was the sole source of employment in the area, has been depleted or closed, is as totally and permanently removed from the possibility of employment as his physically disabled neighbor. He, too, should be entitled to immediate benefits.

While down the road economic development or relocation programs may reverse the economic deterioration of his community or open up future jobs such hope is not meaningful for a person of his age. The present law which requires him to wait until age 62 and then offers him a benefit substantially reduced from already inadequate levels is to condemn him and his family to perpetual poverty and to burden public assistance with additional costs.

Finally, I would urge this Committee to face up now to the contribution of general revenues toward the financing of our Social Security system. Such a contribution has been recommended by innumerable advisory committees beginning with the Council of Economic Security whose report led to the enactment of the Social Security Act. It was proposed as well by the technical staff of this committee in 1946.

A contribution from general revenues is the only fair and equitable method of financing the social costs of the system which benefit society as a whole rather than the contributors to the fund. Among the social costs are full benefits for those who were not in the work force long enough to contribute fully for their benefits, the weighting of the benefit formula in favor of the many low paid workers as well as those affected by the minimum benefit.

Such a program of benefits and financing would result in a Social Security system which would move toward meeting the needs of our aged. It would at the same time offer tax relief to the wage earner and his employer who now are called upon to totally finance the cost of our Social Security system. The savings in welfare costs which would result from adequate Social Security benefits would also offer fiscal relief to the states and the local property taxpayers on whom too much of the burden of relief now fall.

WELFARE PROPOSALS

President Nixon in his statement of August 18, 1969, expressed grave concern over the way our present welfare system is operating. He branded it as a "colossal failure."

The community groups in the ghettos and barrios with whom we are working have had first hand experience as clients of the current system. They share the President's concerns, and they recognize that his proposal which is embodied

in HR 14173 represents a significant step towards an increased federal commitment to revise America's welfare system.

We therefore support many of the concepts for welfare improvement contained in HR 14173. At the same time if the program is to meet the needs of the disadvantaged as well as to meet the goals set forth in the President's message it must be revised in several respects.

Federally financed benefit floor

HR 14173 provides for the establishment of a floor to the income of those families with children and to the aged, the blind, and the disabled. While the establishment of a floor and the increased federal financing is a significant step toward the national standard which we as a nation should guarantee, the levels set forth in HR 14173 would still require the poor and disadvantaged to subsist on less than adequate income. For a family of four the proposed \$1,600 is less than one-half of \$3,555, the official government poverty level.

In his statement before this Committee the Secretary of the Department of Health, Education and Welfare, with respect to the current system, set forth "key areas which needed immediate solution and redirection." Two of the four listed are:

1. "The gross inequities that existed between categories of persons equally in need under the present welfare system";

2. "The gross inequities from State to State." We submit that if a solution in these areas is to be effective, HR 14173 is not the answer.

HR 14173 does not remove the inequities which now exist between "categories of persons." While a standard is set for families with children, no provision is made for the childless couple or the single individual who has equal need for assistance.

Even within the categories of persons for whom HR 14173 mandates a standard, the inferior treatment of families with children which exist under the present system is continued as contrasted with the treatment recommended for the aged, the blind, and the disabled.

Similarly HR 14173 does not remove the "gross inequities from State to State" particularly with respect to the family assistance program. While the \$1,600 payment for a family of four would raise the benefits to individuals in 10 states the proposal does nothing to remove the inequities which exist between families within the other 40 states.

In an attempt to assure that the 40 states which now provide higher benefit levels than \$1,600 to a family of four do not reduce the levels of assistance, HR 14173 requires the supplementation of the federal benefit to current state benefit levels. We agree that if the federal government is not prepared to provide benefits adequate for a minimum standard of living, the states should not be permitted to reduce benefits from the current level. We would suggest, however, that the sanction to assure the cooperation of all states in the program is not a reduction of federal funds for other welfare programs. In any state which does not participate to supplement the basic federal benefit to current state benefit levels, or in any state which undercuts the federally established eligibility standard for the basic family assistance benefit, the federal government should have the authority to provide benefits directly to assure that the welfare recipient does not suffer.

Relationship to the labor market

At the heart of the family assistance program proposed in HR 14173 is the supplementation of the income of the "working poor" and the requirement that recipients register for and accept work or training as a condition of receiving benefits.

We believe that the basic answer to the problem of the working poor and the unemployed is a program of jobs at decent wages. As we have already pointed out, this can be accomplished through provisions for a job creation program with public service employment as a key element and a minimum wage of at least \$2 an hour for all jobs.

We recognize, however, that pending the establishment of such programs the working poor and the unemployed should be guaranteed a minimum level of living. We therefore support the inclusion of families with a working member in the system. We would recommend, however, that if the system proposed by HR 14173 is not to become a permanent system for subsidizing employers who pay substandard wages, this Committee take legislative action which is clearly within its jurisdiction.

We recommend that the legislation reported out by this Committee spell out in specific detail the standards that will govern the work content and the wages of jobs which workers will be required to accept as a condition to the receipt of benefits. The proposed statutory requirement that the employment be "suitable" is not sufficient; and the experience with the interpretation of that phrase under our unemployment insurance system is not encouraging. Even under the unemployment insurance system Congress recognized that certain statutory standards were necessary to preclude any state from denying benefits to a worker who refuses a job which is vacant due to a labor dispute, which is substandard in relation to prevailing wages and conditions, or which would preclude him from joining a bona fide labor organization. Such statutory standards are contained in Section 3304 (a) (5) of the Internal Revenue Code. Statutory standards are even more necessary in a program dealing with individuals with little job experience and for whom unemployment insurance standards have little relevance. "Guidelines" established by the Secretary of Labor and administered by the states are not sufficient.

To avoid the permanent subsidy of low wage employers we would recommend an additional standard. No individual should be required to accept a job which pays less than the hourly wage rate established by the Fair Labor Standards Act for non agricultural employment where such wage rates are less than those prevailing in the area. Acceptance of any job which pays a wage rate of less than \$1.60 per hour should not be a condition to the receipt of welfare benefits. To require otherwise would be to invite a repetition of the British experience in the early days of its welfare program when employers of low wage labor were assured of a continued work force of welfare recipients.

With respect to the basic question of whether welfare recipients should be required to work, we recognize that the provisions in HR 14173 which would exempt mothers of pre-school children from the requirement to take work or training is an improvement over present law. We believe that the experience under current law plus the strong work incentive contained in HR 14173, which we endorse, makes unnecessary a requirement that any welfare recipient be required to work as a condition of receiving benefits.

At a minimum, we would strongly recommend that the proposed exemption be extended to mothers of school age children.

We believe that if sufficient day care centers were established through federal support of their construction and operation, the requirement for any mother to work would be superfluous. More than enough mothers would make the decision on their own initiative as would fill available jobs.

It should also be recognized that the requirement that other recipients automatically register with the employment service without any finding that jobs or training for jobs are available represents a retrogression from current law which requires that a preliminary determination that work or training is "appropriate" for the individual recipient.

The time is long overdue for America to provide an adequate income for its aged, its disabled and its disadvantaged. We urge this Committee to take immediate steps to achieve this goal. The above sets forth our recommendations for action.

Mr. LESSER. The Committee for Community Affairs is a nonprofit corporation organized under the laws of the District of Columbia. It has received a tax exemption as a social welfare organization under section 501(c) (4) of the Internal Revenue Code, and among its other purposes, it represents and speaks for community organization of the poor and the disadvantaged.

Among the community groups with which we work are the Watts Community Labor Action Committee, the East Los Angeles Community Union, community groups in Texas, in Newark, New Jersey, and in Chicago.

These groups of course are primarily concerned with those provisions in the Social Security Act which are aimed at providing adequate income to the poor.

Normally one thinks only of the welfare provisions, title I, title IV, title X, and title XVI, which provide cash assistance to the needy, when one thinks of welfare programs aiding the poor.

Yet, this committee, in scheduling hearings covering all titles of the Social Security Act, obviously recognizes the interrelationship between the provisions of social insurance and the welfare provisions.

Obviously, to the extent that old age insurance benefits are so low that millions of the aged who depend on them live in poverty, assistance programs for the aged become more important to these people.

They become saddled with a bigger burden, and more attention is focused on the need to improve the levels of welfare, and more concern is expressed about the costs of welfare.

On the other hand, to the extent that social security benefits are raised to assure a decent standard of living to the aged, then the cost of old age assistance is reduced, and even with improvements in its benefits, it can be kept within reasonable levels.

Another area of interrelationship is the unemployment compensation program hearings, which you have just concluded, and the recommendations for legislation which have been reported by this committee.

Let me give a concrete example. One of the items which this committee failed to recommend was coverage under the unemployment compensation laws for agricultural workers.

Obviously, now, agricultural workers, when they are not working, when they are without income, will be forced to turn to assistance programs for relief. Were they covered by unemployment insurance, were they receiving benefits under unemployment insurance, they would not have the same need for welfare, and welfare costs would not be burdened with their maintenance.

We can carry this all the way through in the welfare system. We have all read, we have all analyzed the criticisms of the rising welfare rolls, but one of the real problems is that welfare is looked upon as the single program to relieve all of the deficiencies of other programs which are aimed at providing jobs and income to people.

If there were an employment program, if there were jobs, if there was public service employment providing jobs at decent wages, people would not be forced to turn to welfare. If the minimum wage were raised so that people who work 2,000 hours a year would receive an adequate wage, there would be no need for a family assistance program to supplement the income of the working poor.

People who are working, many millions, I believe the figure is 5 million, are working 2,000 hours a year, working fulltime, and still receive incomes from their work below the poverty level.

Welfare should not be blamed for the deficiencies of inadequate wages. It should not be blamed for the deficiencies of the failure to enforce nondiscrimination programs which results in much higher rates of unemployment for the minority groups.

We should aim our effort at the enactment of programs which provide jobs, which provide wages, and the improvement of social insurance programs to take care of people when their wages are interrupted because of unemployment, because of disability, or because of retirement.

With these considerations in mind, I would like to turn now to some of the specifics of the bills before you, primarily the administration program, H.R. 14080, which would improve the Social Security Act, and point out why we think it does not go far enough. Why we think

the provisions of the bill introduced by Congressman Gilbert offer some hope to the aged persons of America.

By any reasonable standard, social security benefits are strikingly low. Present law provides a minimum of \$55 a month or an annual income of \$660 for an individual, and \$990 for an aged couple.

Compared to \$2,900, which is the amount which the U.S. Bureau of Labor Statistics has found necessary for an aged couple to live at a "low" level, its inadequacy is apparent, \$1,910 a year.

Even the aged couple who receives the average social security benefit is still forced to live with an annual income of \$884 below the level needed for minimal decency.

Is it any wonder that 20 to 25 percent of the Americans who are living in poverty are above the age of 65?

H.R. 14080, the administration bill, proposes to meet this problem by increasing current levels by 10 percent, with a new minimum of \$61 a month. The proposed annual increase in the minimum of \$72 a year for an aged individual and \$108 for an aged couple hardly moves toward meeting the deficiency of \$1,910 which now exists between minimum benefits for an aged couple and their required budgetary needs to meet the "low" level of living set forth by the Bureau of Labor Statistics.

The strange thing is that this inadequacy is highlighted by the provisions of H.R. 14173, also proposed by the administration, which recommends a minimum of \$90 a month for the aged blind or disabled welfare recipient, and \$180 a month, or \$2,160 a year, for a couple, both of whom are aged and are on welfare.

Why should not our Social Security System, which is the most widely accepted program enacted in the last 35 years, which covers practically all of the aged, to which people contribute while they are working, not provide at least the minimum benefits proposed under our welfare program?

Why should the beneficiaries of social security, who, as I say, have contributed during their working life, be required to turn to an assistance program largely financed from the Federal Treasury to be assured of an adequate income?

We would therefore strongly urge that this committee at least report out a minimum for social security equal to the minimum proposed by the administration for aged welfare recipients.

Actually, we would urge an immediate minimum of \$100 for the aged recipient.

There are many other proposals we could talk about. I would like to just mention two, since they affect those aged persons at the minimum level of living, because of the minimum income which they enjoy.

The first is the aged widow, who now receives a benefit equal to 82½ percent of the benefit to which her spouse is entitled.

We would urge that the administration recommendation, that it be made 100 percent, be accepted. We would only urge that it not be limited to aged widows who first come on the rolls after the age of 65. We would urge that it be made applicable to aged widows who are entitled to benefits at age 62, and with respect to whom the administration proposes reduced benefits. We believe they, too, should be entitled

to 100 percent of the benefits to which their spouse would have been entitled.

Another proposal, which is not contained in the administration bill, is a proposal which would deal with aged persons, persons at the ages of 60, 62, who live in areas which are struck by an economic blight.

The best example is in areas such as Appalachia. When a mine, which may be the only source of employment in the area, is depleted and the worker is age 60 or 62, he has no alternative but to look for Social Security benefits. If his neighbor is physically disabled, he is entitled to full benefits under the Social Security Act. We would suggest that an individual who is technologically disabled, in a sense, be entitled to the same consideration.

While we would continue to urge economic development programs, relocation programs, to help those areas, it is unlikely that any of these programs will help a worker who is aged 60 or 62.

Finally, let me turn to the welfare program proposed by the President in H.R. 14173. In his message, or his statement, really, of August 8, President Nixon expressed grave concern over our present welfare system. He branded it as a colossal failure.

The community groups in the ghettos, in the barrios, with whom we are working, have had first-hand experience as clients of the existing system. They share the President's concern, and they recognize that his proposal which is embodied in H.R. 14173 represents a significant step toward an increased Federal commitment to revise America's welfare system.

We therefore support and endorse many of the concepts included in H.R. 14173, specifically, the provisions for the establishment of a federally financed floor to the income of those families with children.

We would only urge that it not be limited to families with children, that it include a couple without children, that it include the single individual who is equally in need of assistance.

We endorse the proposal for eliminating the widely varying definitions of eligibility for aid to dependent children, or aid to families with dependent children, in the current law, and the substitution of a national program of basic eligibility which also covers families with unemployed or working fathers. We believe that this is a constructive step forward.

We endorse the features of the program which offer incentives to work, to welfare recipients, which would permit their income to be increased as they work.

We believe, however, that, if the program is to make the progress which is needed to meet the needs of American disadvantaged families, it must be clarified, and it must be strengthened in several respects.

First, with respect to the level of benefits, we think it is clear that the level of \$1,600 for a family of four, which is less than half of that level set and recognized by the Federal Government as the poverty level, namely, \$3,550, that \$1,600 is obviously too low.

The administration's program would require that States maintain their current levels when higher than \$1,600, and I might point out that \$1,600 is greater than the level provided in only 10 States under the current law—in other words, there are only 10 States where a family of four now receives less than \$1,600. The administration proposal which would require the States to maintain their present levels, we do

not believe, provides adequate assurance to require the States to do so.

H.R. 14173 would propose that if States fail to cooperate, if they fail to maintain the level, the Federal Government will cut off Federal grants for assistance to other categories of individuals.

We do not think that penalizing other persons on welfare is the way to get States to comply with the family assistance program.

We would suggest instead that in States that fail to comply, or in States that undercut the Federal eligibility standards, the Federal Government have the authority to go in and pay the benefits which otherwise would be paid, and not reduce payments to other families who are in need.

Secondly, and probably most importantly, we urge that the legislation spell out the standards that will govern the work content and the wages of jobs which workers will be required to accept as a requirement for continued receipt of family assistance benefits.

I talked briefly about the general question of compulsion, but I would like to point out that the great danger of any system which supplements the income of working poor, and I might say we do support that, but the danger of the system is to assure that it will not create a perpetual class of welfare recipients on whom low-wage employers can continue to call to provide work at substandard wages.

As I said, we think the primary emphasis has to be on raising the minimum wage, but beyond that, and within the jurisdiction of this committee, it should specifically be provided that, if there is going to be a compulsion to accept jobs, no individual should be required to accept work or training for work that will pay less than the higher of the hourly wage rate established by the Federal Minimum Labor Standards Act for nonagricultural labor, which today is \$1.60, or the prevailing wage.

We are particularly disturbed that H.R. 14173 even eliminates those standards which now exist in the WIN program, which talk about the minimum wage where applicable or the prevailing wage.

The Secretary of Labor, in testifying before this committee, indicated he would establish Federal guidelines and place great reliance on the use of the word "suitable," and the interpretations given to that phrase "suitable" under the State unemployment compensation laws.

As somebody who has been involved in the unemployment compensation program for more than 25 years, I might say I don't place great reliance on interpretations of "suitable work" under State unemployment compensation laws.

In any case, I hardly think the concepts of suitability which have been developed with respect to persons who have been continuously in the labor market bear much relevance for people who have never been in the labor market, and whom we are trying to encourage to get into the labor market.

I therefore urge most strongly that this committee write in specific standards to the welfare provisions which they might report out.

The Federal Unemployment Compensation Act contains specific standards which preclude any State from requiring a person to accept a job which is vacant due to a labor dispute, which pays less than the prevailing wage, and which would require an individual or prohibit an individual from joining a union.

If Congress thought it important to write in standards to control unemployment compensation interpretations, I think it is all the more important for the Congress to write in standards with respect to requiring welfare recipients to accept jobs.

Finally, let me just mention one other point, because I realize my time is running short.

With respect to the requirement in H.R. 14173 that all welfare recipients be required to register for work at the employment service, even under current law the program adopted by the Congress in 1967, before an individual is required to report and register for work, a determination must be made that such registration would be appropriate for the individual.

While I commend the administration in H.R. 14173 for setting forth various categories of individuals who will not be required to register, among them mothers who have preschool children at home, which I think is an improvement over present law, yet, why, under all circumstances, should individuals be required to register?

Let me give you one example. In the Watts area of Los Angeles, the most recent figures on unemployment, which came out by the Federal Government, indicated an unemployment rate of 15 percent. Now, with 15 percent of the labor force unemployed in Watts, with the lack of jobs in the Watts area, with the lack of transportation from the Watts area to jobs, what would be the sense of requiring welfare recipients to register for jobs, when there are no jobs in the area?

It is one thing, where there are jobs. It is another thing, where there are no jobs. The only purpose of registration is to require a futile gesture and the opportunity to cut people from the rolls if they don't register, even though registration will do nothing to get them a job.

We therefore urge that consideration be given to reviewing the situation and rejecting the blanket requirements contained in H.R. 14173, at least without a preliminary determination that registration is appropriate for the individual recipient or for the area in which the recipient resides.

In summary, Mr. Chairman, we believe the time is long overdue for America to provide an adequate income for its aged, for its disabled, and for its disadvantaged. We urge a whole series of programs to accomplish this result.

We urge this committee to take immediate steps to achieve this goal by the enactment of an adequate social security, and the enactment of an adequate welfare program.

The above sets forth our recommendations for action.

Thank you, Mr. Chairman.

Mr. FULTON. Thank you for a very excellent presentation, Mr. Lesser.

Are there any questions?

Mr. GILBERT. I would like to ask a question.

Mr. FULTON. Mr. Gilbert.

Mr. GILBERT. Personally, I want to welcome you here, Mr. Lesser, and commend you for your fine presentation.

One of the problems that plagues me and other members of the committee is the possibility of, or the reality, I should say, of a social security increase of let us say 15 or 20 percent, whatever it may be. Many of our older people of course have their social security income

supplemented by old age assistance. Now, if they receive this increase in social security benefits, they may have a corresponding decrease in old age assistance.

How would you recommend that we handle this problem?

Mr. LESSER. Well, of course, my first recommendation, Congressman Gilbert, would be the adoption of your minimum, which would alleviate the necessity of most of these persons turning to welfare.

Short of that, I believe that even while H.R. 14173 does not meet that problem, it points the way toward it. H.R. 14173 recognizes that in considering the income of an individual, and measuring what his benefit level should be, a certain amount of "nonearned income" should be exempted, as well as earned income, that is, wages, and I believe they specifically include in the nonearned income which should be exempt, survivor's benefits.

Now, they do not include primary benefits under the Social Security Act.

I would suggest that primary benefits under the Social Security Act be included in the category of exempt income in determining the welfare level.

In other words, it would be quite easy for this committee to say, and I know there have been suggestions, for example, which have said any increase which Congress enacts cannot be taken into account by a State agency. In other words, they could not reduce the welfare benefit by the amount of that increase.

I would suggest that even beyond that, perhaps the committee should give consideration to saying:

You cannot reduce the welfare benefit by one-half of the primary social security benefit which we provide under the Social Security Act.

Mr. GILBERT. I thank you, because this is a problem that has bothered me a great deal.

Mr. LESSER. It certainly is.

Mr. GILBERT. I think it would be grossly unfair that a person receive an increase in social security benefits, and then on the other hand have his income level remain about the same. It would be almost a futile gesture.

Mr. LESSER. That is right.

As I say, I cannot recall the categories off-hand, but I think, for example, private pensions are included in the category of unearned income, where the administration proposes an exemption of one-half. I think that that would be the way I would prefer, rather than just dealing with this increase, to deal with the total amount of the social security benefit.

Mr. GILBERT. I understand that one-half is disregarded only for family assistance and not for adult assistance.

Mr. LESSER. What was that?

Mr. GILBERT. One-half is disregarded only so far as family assistance goes.

Mr. LESSER. I suggested that as the approach. Obviously you have to do it for the aged, the disabled, as well as under the family assistance. I agree.

But I said they have suggested the approach. I think if you took it and applied it to Title I, dealing with the aged, Title X, the blind and

disabled, et cetera, you could accomplish the result you are seeking.

Mr. GILBERT. Thank you very much, Mr. Lesser.

Mr. FULTON. Mr. Corman.

Mr. CORMAN. Thank you, Mr. Chairman.

Mr. Lesser, I am very impressed with your statement. I wanted to underscore your observations with statistics.

I shared your disappointment that the committee did not extend the unemployment insurance coverage to agricultural workers.

In December 1968, 10,800 fathers were added to the welfare rolls, and of those, 7,000 had received no unemployment compensation within the past 6 months before they applied for their benefits.

Obviously, anything we do to expand unemployment insurance cuts down on the amount of welfare that we must spend, and it seems to me puts it in an entirely different category so far as the recipient is concerned.

On the mandatory employment, I have been very concerned about a probable lack of uniformity in the application of that requirement. It may be used in some parts of the country just to clean out the welfare rolls, to take people off of welfare.

When we take the mothers of dependent children, that is a substantial part of the people who are on welfare. It is obvious that we are not going to have adequate day care centers for very many children very soon.

Don't you think we would be wise to leave out any mandatory requirement so long as all available child care centers are filled by women who voluntarily place their children in those centers and go out and work?

Mr. LESSER. I agree 100 percent, Mr. Corman. In fact, in my prepared testimony I point out that the voluntary registrants for work have been more than adequate to fill the available jobs.

I also point out and would urge most strongly increased Federal funds for the construction as well as the operation of day care centers.

For example, I have been working with the Watts Labor Community Action Committee, which has a proposal pending in the Department of Health, Education, and Welfare for the construction of and operation and maintenance of 5 day care centers, because they are concerned about the mothers who want to go to work but have no place to leave their children.

One of the problems that we are running up against is the lack of money to aid in the construction of the day care centers.

Mr. CORMAN. I think everyone has been concerned about the fact that the welfare rolls are growing, with more people on them all the time, and some people conclude that the women are having children just to get on welfare.

But as I understand the situation, of all the people who are presently eligible, only about half are getting public assistance now, and so, if we had no more births, we would double the present welfare roll, if all the people who are eligible started drawing it. Is that correct?

Mr. LESSER. I think that is right, although my recollection is that the figure of half is high. I had thought that less than half of the people who were eligible are on the rolls.

I think you are right. I think it is terribly important to stress that we are all concerned about the growing burdens, but it is important to look at why.

This is why I say if Congress raised the minimum wage, it would eliminate the 5 to 8 million people who I think, are working full time but who are below the poverty level. Now, those people, to the extent that they are covered by welfare, can be removed. It is not their fault that they are on the welfare rolls. Their wages are too low. If their wages were raised, they would be off the welfare rolls.

If the social security benefit minimum were raised to \$100, 25 percent of the aged who are below the poverty level would be off the welfare rolls.

We cannot really blame welfare if we expect it to make up for all of the deficiencies of every other program which we have failed to enact, or which we have not improved to an adequate level.

As I point out in my testimony, the President in the economic report said it would take \$9.8 billion to bring everybody below the poverty level up to the poverty level.

Now, if we say one program has to bear that additional cost of \$9.8 billion, we know we have doomed it to failure, because this Congress will not enact it, and anybody proposing it gets subject to criticism for proposing a \$10 billion program.

But if we look at the people who are below the poverty level, and say a job creation program will remove so many people, adequate social security will remove so many people and bring them up to the poverty level, decent wages will bring so many people up to the poverty level, then we leave to welfare a very small group of people who because of one circumstance or another, do not fall within the scope of these basic programs. At that point, I don't think we would have the criticisms of welfare that we now do have.

Mr. CORMAN. There has been some concern expressed that if we raise the minimum to the poverty level, so that people on public assistance will have a decent diet and some decent place to live, that this might remove incentive to work.

Others conclude that having an adequate diet and some reasonable medical care and a halfway decent place to live really is a first step toward motivating people to live in society and comply with the laws.

Would you comment as to your own observation of the people you have worked with in Watts and other places?

Mr. LESSER. Well, we have found that the motivation is there, and you are right, that once a person's income gets up to a reasonable level, he can see the goal of higher income and wants to earn more.

In other words, one of the complaints of many of the people on job training programs and job programs now is that they are brought in at the lowest level, and there is no job ladder created for them to move up, and at a certain point they are at this level, and they see that that is the end. Those programs that have established a ladder have found that the motivation is there for people to take additional training to move up the job ladder to increase their income.

I think that the incentive contained in the President's proposal, even with higher benefit levels, bringing them up to the poverty level, would encourage people to work. The fact that a certain amount of the earnings are disregarded, the first \$60 a month, 50 percent of additional earnings, would mean that even though a family of four was getting the \$3,500 which is the poverty level, there would be quite an incentive for them to earn more and improve their lot.

Experience has certainly demonstrated that there are very few people who are content to live at a poverty level when the opportunity is there for them to earn more.

MR. CORMAN. If we couple that incentive with a reasonable diet and halfway decent living conditions, we probably would move more people from the welfare rolls. Is that a fair assumption?

MR. LESSER. I think that is quite so.

I add one additional factor—decent education.

MR. CORMAN. Thank you very much.

MR. FULTON. Thank you, Mr. Lesser, for bringing this excellent statement to the committee.

MR. LESSER. Thank you.

MR. GILBERT (presiding). Mr. Walter Newburgher.

STATEMENT OF WALTER A. NEWBURGHER, PRESIDENT, SENIOR CITIZENS OF GREATER NEW YORK

MR. NEWBURGHER. Mr. Chairman—

MR. GILBERT. Mr. Newburgher, would you please state your name and the organization you represent?

MR. NEWBURGHER. I will.

Mr. Chairman and other distinguished members of the Ways and Means Committee, my name is Walter Newburgher, and I am president of the Congress of Senior Citizens of Greater New York. This is a nonpartisan, nonprofit organization of 124 older people's clubs, with over 150,000 members. These clubs include so-called "golden age" groups, day centers, clubs connected with the "Y's," and union retiree groups.

The executive board of the Congress of Senior Citizens is in unanimous agreement that the Social Security system is the first line of defense against poverty.

However, this line is not holding, and must be greatly strengthened.

Not only is the first line of defense pitifully inadequate but the second line of defense has been so seriously weakened by unwise legislative action that our executive board has asked me to come here to express the feeling of our organization about the weakness of social security and welfare as they now operate in New York State.

In New York City alone there are an estimated 1 million men and women age 65 or over, the great majority of whom must make do on fixed incomes that are being steadily reduced by the inexorable rise in prices, month after month, year after year.

Large numbers are desperately poor and stand in need of substantial increases in income to enable them to achieve a life of dignity and security.

Instead of compassionate concern for their suffering and deprivation, the New York Legislature, with the approval of Gov. Nelson Rockefeller, has ordered meat-tax cuts in State welfare payments, and in Medicaid, the Federal-State health program for the needy.

Our organization, the Congress of Senior Citizens of Greater New York, protested these cuts. More than 1,000 delegates of our organization joined with representatives of church, civic, labor, and other humanitarian groups in a mass meeting on the steps of the capitol at Albany last April.

Standing in a drizzling rain, these dedicated men and women requested restoration of the welfare and medicaid cuts, and asked the legislature for a \$100 million bond issue to finance needed rental housing, increased homemaker services, and more cultural and recreational programs for older people.

The protesters drew assurances of support from prominent legislators, including State Senators Seymour Thaler, Manfred Orehstein, and Basil Patterson, Assembly Minority Leader Stanley Steingut, Assemblymen Albert Blumenthal, Larry Simon Ben Altman, Robert Abrams, Seymour Poser, and Charles Rangel.

Nevertheless, the Governor and the majority leaders of the legislature held aloof. The legislature adjourned without reconsidering the welfare and medicaid cuts.

Since then the groups represented at the Albany protest demonstration have sought to persuade the Governor to call a special session of the legislature to lay before it the critical situation the welfare and medicaid cuts have caused. Regretfully, I must report the Governor has turned a deaf ear to our appeals.

He did so again in this very room, when my Congressman, Jacob H. Gilbert, who is a member of this distinguished committee, asked Governor Rockefeller, when the Governor testified here last week, if he might call a special session of the legislature to consider the protests against the welfare and medicaid cuts. His answer was that it would be only a short time before the legislature meets in regular session.

Mr. Chairman and other distinguished committee members, I will let the spokesmen for the victims of the savage cuts in the New York welfare and medicaid program tell about its unfortunate consequences.

At a hearing on the cuts held by the United Neighborhood Houses, Inc., 114 East 32d Street, New York City, many witnesses testified to the hardship and deprivation they suffer because of the cuts. There were 75 organizations including the Congress of Senior Citizens, represented at this hearing.

Dr. Arthur C. Logan, president of Neighborhood Houses, said the 75 organizations called on the Governor to convene the legislature for the purpose of resolving the welfare crisis. In a statement summarizing the hearing consensus, he said :

There must be a way to see to it that children on welfare have adequate clothing and nutrition, that sick people have the money for special diets, that old people living alone have telephones so that they can get help when they need it. The special allowances covering such vital needs have been cut out of welfare assistance in the course of a general reduction which runs from eight to fifteen percent. This at a time when the cost of living is going up at the rate of six percent a year.

Less than 2 weeks after this hearing, the Governor and State legislative leaders announced restoration of \$5 to \$8 per month to aged, blind, and disabled welfare recipients. This is the equivalent of from 16 to 26 cents a day in added income, or about enough for coffee or coffee and a doughnut.

Dr. Logan had this comment :

It seems imperative that welfare recipients in all categories be given some relief from the extreme deprivation in which they now find themselves.

In view of the sharply rising cost of living, the cuts enacted by the Legislature have clearly gone deeper than was anticipated when they were enacted in March. The hardship and suffering of welfare recipients, as brought out at our hearing, cry out for a humane response.

In the view of our organization, and many other groups in contact with the poor, the 20-percent coinsurance for the medically needy not on relief incorporated in the New York State medicaid program was outrageous. This effectively prevents early detection of serious disease.

Medicaid has been gutted in three stages. The regulations were watered down a few weeks after passage. Then there was the elimination in 1968 of medicaid benefits for all between the ages of 21 and 65. This year the legislature made a mockery of a program designed to provide modern health care for the needy by imposing a 20-percent coinsurance requirement that has the effect of preventing the needy from using the program.

I have alluded to last week's testimony by Governor Rockefeller before your committee. I doubt if he told you of the disastrous effect of the welfare and medicaid cuts in New York City and other urban centers.

There was a time not so long ago when New York State was the model for our Nation in legislation for and on behalf of the poor and disadvantaged. New York is the most powerful and productive State of the greatest nation in the world, but, with enactment of the welfare and medicaid cuts, it lost its once bright reputation for humanitarian concern for all its citizens, rich and poor. The New York Legislature, and Governor Rockefeller by approving these cuts, has, I am sorry to say, turned back the clock in New York State by shortsighted disregard for its poor, including the elderly poor.

The Congress of Senior Citizens of Greater New York is represented on the New York Committee of Aging and Disabled for Welfare and Medicaid.

We ask these improvements in medicaid:

Establish eligibility for medicaid if annual income is no more than \$4,000 for a person living alone, or \$5,000 for a two-person family. (The current eligibility is \$2,000 and \$3,100, respectively.)

Permit older and disabled medicaid applicants to keep \$2,000 in savings in the case of single persons or \$3,000 for a two-person family, and a burial reserve of \$1,000 per person. (Presently, savings permitted are \$1,100 for single persons and \$1,550 for a two-person family.)

Elimination of the new requirement that nonwelfare medicaid recipients pay the first 20 percent of nonhospitalization medical costs.

Reimbursement of full payment for all dental services, including false teeth, when needed.

We hope the modest monetary improvements offered the elderly, blind, and disabled will be followed by further improvements in the adult categories and adequate improvements to the other categories of public assistance recipients. Older and disabled people have no desire to be separated from the remainder of the human family. Everyone in need continues to suffer, regardless of age.

As I said at the outset, the Congress of Senior Citizens of Greater New York regards the social security system as the first line of defense against poverty. However, it falls far short of its potential for a better America.

Even the highest social security retirement benefit—\$160 a month for a worker retiring this year at age 65, or \$247.50 for a couple—provides less than the amount the U.S. Labor Department finds

necessary for a modest level of living—\$3,857 a year for a retired couple to enjoy a modest level of living.

That is why the Congress of Senior Citizens of Greater New York supports the Gilbert bill, H.R. 14430, providing 15 fundamental improvements in the social security law, including an overall 50 percent increase in social security benefits. It would provide a minimum benefit of \$120 a month by 1972, more than double the present pitiful \$55 a month minimum; abolish the present \$4 a month premium for medicare part B (doctor) insurance; and pay for out-of-hospital prescription drugs, now excluded from coverage under medicare.

Our organization endorses the testimony of Nelson H. Cruikshank, president of the National Council of Senior Citizens, given before this committee on behalf of the Gilbert bill the same day Governor Rockefeller was here. I will not repeat his testimony.

However, I would like to emphasize the importance to our members and elderly throughout New York State of the proposal to extend medicare to cover out-of-hospital prescription drugs.

The tremendously high cost of prescription drugs presents a great many elderly in need of costly medication with a choice of having enough to eat, or buying medication needed to preserve life and promote health.

Forty-nine percent of the men and women age 65 or older have chronic ailments, the U.S. Department of Health, Education, and Welfare reports. These men and women usually are on medication of one kind or another, and it is often exorbitantly high priced.

Two official groups have recommended that medicare be extended to cover out-of-hospital prescription drugs—a task force of top officials of the Department of Health, Education, and Welfare, which made its recommendation last February, and a 17-member review committee of distinguished civilians, who made their recommendations last August.

The review committee said:

The requirements for appropriate drug therapy by the elderly are very great—far greater in fact than those of any other group—and many elderly men and women are now unable to meet these needs with their limited incomes, savings, or present insurance coverage.

It is regrettable that, despite the findings of both these very competent groups, Secretary Robert H. Finch of the Department of Health, Education, and Welfare has not recommended that Congress make this most desirable improvement in medicare.

My organization, the Congress of Senior Citizens of Greater New York, welcomes the recognition by President Nixon in his welfare message to Congress of the need for a reorganization of the present federally aided poor relief system.

The members of my organization feel, however, the President's legislative proposals reveal a glaring omission that must be corrected.

These proposals do not include childless couples and individuals under 65 living alone.

I am duplicating the testimony of Mr. Lesser.

I have read the President's proposals, and I must tell you frankly they would do very little to resolve the welfare problems of my home town, New York City. I am not alone in this opinion. You heard it presented before this committee last week by a distinguished spokesman for the poor and disadvantaged of New York City, Rev. Robert

P. Kennedy, director of the Social Action Office, Catholic Charities of the Diocese of Brooklyn.

Mr. Chairman and other distinguished members of the committee, how is it possible to forget or ignore such a significant segment of the poor and disadvantaged? I hope and trust you will take notice of this critical omission.

On the subject of welfare, I wish to protest the practice in New York and many other States of deducting from welfare payments the amount of a social security increase in the case of men and women whose social security benefits are so low they must ask for public assistance.

The members of the Congress of Senior Citizens of Greater New York support the proposal of President Cruikshank of the National Council of Senior Citizens in his testimony here last week, that Congress permit no State to offset social security benefits against old age assistance payments in any instance where the sum of the two is lower than the poverty level as determined by the appropriate Government agency.

Mr. Chairman and members of the Ways and Means Committee. While this concludes my statement on behalf of the Congress of the Senior Citizens of Greater New York, I have a further short statement. I would like to introduce into the record on behalf of Mayor John V. Lindsay of the city of New York.

I am a member of the Mayor's Commission on Inflation and Economic Welfare and I had the honor of being present the day before Mayor Lindsay's reelection when, at City Hall, the preliminary report of the commission was submitted to the mayor.

Knowing that I was scheduled to appear before this committee today, Mayor Lindsay asked that I present you with a brief report of some of the recommendations of this commission. The four most urgent recommendations are as follows:

First, we recommend that New York City take the lead in establishing a Council of Urban Economic Interests, to be financed from contributions from individual city governments, equipped with a substantial and capable staff in Washington.

The objective of this institution would be to mobilize and focus the political power of city governments on behalf of the economic interests of cities and citizens of the cities, interests which Federal authorities seem consistently capable of ignoring under present circumstances.

Second, we recommend that Congress enact before the end of 1970 a revenue sharing plan which distributes at least \$5 billion or 2 percent of the income tax base to State and local governments under a formula for allocation that insures that New York and other cities are not further deprived of the capacity to meet their growing responsibilities by the devastating impact of inflation and a shrinking tax base.

Third, we recommend that the city of New York prepare and present to the State Legislature of New York in the next session, a proposal for drastic reform of the health care system to assure every New Yorker comprehensive services for a single insurance payment that reflects each family's ability to pay; we single out this recommendation for special mention because medical costs are the fastest rising item on the consumer price index, because structural obstacles to economy and efficiency are especially prominent in this area, and because

reform of the health care system is an area in which the city can most effectively fill the breach as an advocate of consumer interests.

Fourth, we recommend that the city press for reform of the tax system—Federal, State, and local—to achieve equitable distribution of the burden; to reduce the tax bill of the average New York City family, which now pays too large a share of the cost of government.

I would also wish to present to the attention of the Ways and Means Committee the mayor's commission's observations regarding the elderly and social security benefits which were as follows: The entire report, of course, is that thick.

Mr. GILBERT. Excuse me, Mr. Newburgher.

Is this the complete statement that you wish to read or did you want that included in the record as if it is read?

Mr. NEWBURGHER. Well, there is just a little more but if you want me to include it in the record—

Mr. GILBERT. It is up to you. Do you want to continue reading?

Mr. NEWBURGHER. I have gone that far and may as well finish, with your permission.

Mr. GILBERT. Go right ahead.

Mr. NEWBURGHER. Regarding: First, the elderly—social security benefits—we have recommended an approach to the problem of inflation based upon careful application of selected restraints while maintaining the benefits and attacking structural defects that cause high prices.

The elderly are a particular group for whom immediate relief is required. They and others living on fixed incomes are often the unwilling victims of expansion policies which too often ignore their stagnant position in a spiraling economy. The savings they accumulate during their productive years are quickly eroded.

At a recent rally of senior citizens a retired insurance salesman complained: "You cut here, cut there, and finally you're going to make due." Such an attitude is not surprising when we consider that in the last 2 years the cost of living for retired couples in New York has risen 10 percent and that it takes 11 percent more to maintain a moderate standard in New York than in other major cities.

The average retired couple now receives \$2,040 a year in benefits from social security. The Bureau of Labor Statistics charts showing the annual cost of consumer goods required for retired couples to maintain themselves at three standards of living attests to the disparity between this average and the modest needs.

This study indicates that \$2,947 is required to maintain a "low standard" and \$4,407 to meet the demands of an intermediate budget. Yet many elderly individuals are forced to live on minimum benefits of \$55 a month.

To raise benefits and permit our senior citizens to live with dignity in retirement we recommend legislation to increase the minimum payment under social security to \$150 a month, to provide substantial increases across-the-board and to provide for periodic and automatic cost-of-living adjustments.

What is required is a continuing effort to guarantee the elderly the economic security to which they are entitled and never to allow the enormous disparities between benefits and subsistence level which now exist.

Second, we recommend the earned-income limitation under social security be substantially increased to enable retired persons to supplement benefits through part-time work without reducing their social security check.

It is essential that we use the talents and abilities of senior citizens in works of social service to the community, that we permit them to supplement their income rather than penalize them for seeking active participation in the society.

On the State level we recommend the repeal of the amendment enacted this year requiring senior citizens whose income qualifies them for medicare but is above the poverty line to pay 20 percent of their outpatient medical bills. This requirement causes senseless hardships to people living on budgets already strained to the limit. It should be eliminated.

Mr. GILBERT. I wish to commend you, Mr. Newburgher, for your fine presentation, and I welcome the support that you and your organization of senior citizens have taken with respect to my bill, the Gilbert bill, on which we have at the present time at least 50 cosponsors in the Congress. If yours and other organizations keep punching away, I look forward to the hope that we may have some pretty good social security legislation enacted this year.

Mr. NEWBURGHER. Thank you.

Mr. GILBERT. Thank you very much.

Mr. CORMAN (presiding). Our next witness is Mr. James Carbray, legislative chairman, Allied Senior Citizens of California.

Mr. Carbray, we are pleased to have you testify before the committee, and if I may say personally, it is good to see a close friend from home come and help us in our deliberations.

STATEMENT OF JAMES CARBRAY, LEGISLATIVE CHAIRMAN, ALLIED SENIOR CITIZENS OF CALIFORNIA

Mr. CARBRAY. Thank you, Mr. Chairman.

Let me reciprocate by indicating my pleasure to have this opportunity to come before the committee, Mr. Chairman, and its members.

My name is James Carbray, a resident of Whittier, Calif. I am an executive board member and chairman of the Legislative Department of the Allied Senior Citizens Clubs of California, Inc., a statewide organization of 270 clubs with a membership of just over 50,000.

As their representative, I wish to register their strong desire for meaningful improvements in social security and medicare—the kind of improvements offered by Congressman Jacob H. Gilbert's bill, H.R. 14430, calling for a 50-percent overall social security increase, much greater increases in the minimum to bring it to \$120 a month by 1972, abolition of the monthly premium payment for medicare part B (doctor) insurance, and extension of medicare coverage to out-of-hospital drugs, among other improvements.

As a retired person in contact with other retirees, I have found among them a feeling of deep disappointment and frustration because the social security system has not come up to expectations when this great program was set up back in the 1930's.

I need hardly remind such a knowledgeable group as the members of the Ways and Means Committee that social security is a wage-

related system of social insurance designed to replace income lost due to retirement, disability, or death. It does not do that for millions of the elderly, I am sorry to say.

As a result, these millions of elderly are impoverished social cast-offs, in an era of unprecedented prosperity for the great majority of Americans.

Undoubtedly the hardships and deprivation borne by millions of social security recipients are very much the same across the Nation. However, I will endeavor to show how elderly poverty adversely affects community development and day-to-day behavioral patterns in southern California metropolitan areas.

During the past few years, many seniors who during their years of employment purchased and paid for homes in preparation for their "golden years" have come to realize that continuing increases in living costs, coupled with spiraling property taxes and maintenance costs, makes continued homeownership prohibitive. As a result, we find thousands of seniors forced to sell their homes and pay rent commensurate with their income.

Rental units of this kind are obtainable only in areas where the properties have deteriorated with age, and in many cases should be condemned. Generally the buildings are crowded, and without adequate heating and sanitary facilities.

One has only to travel through west central Los Angeles to discover that here is a 2-mile square area quickly acquiring all the characteristics of a new slum, in which it is becoming unsafe for anyone, including seniors, to venture out at night, and where the cost of police and fire protection is continually increasing. The cost of such slums far exceeds what it would take under the urban renewal program to eradicate them.

And I would like to pause and add here that the growth of these slum areas in metropolitan Los Angeles is outstripping the efforts of the urban renewal program to replace them. I think this is interesting.

Surely the elderly have earned the right to own, maintain, and enjoy in comfort homes they paid for in their productive years. Surely society has an obligation to protect and preserve these elderly citizens from the erosion that is going on around them.

There are approximately 2 million Californians age 65 or over, and, like millions of other elderly across the Nation, they are becoming increasingly aware of the economic, social, and political facts of life.

And, Mr. Chairman, if I may pause and stray from the script, so to speak, for a moment, during the past 2 years, those of us who have worked constantly with senior citizens' organizations and groups have found a new breed, I would like to call it, if I may, of senior citizens, an enlightened group.

Some of these people are becoming authorities on legislative matters, taxation matters, economic matters, and social matters, and I think it is interesting to note that they are beginning to express themselves commensurate with this new knowledge.

I will go back to the script, now.

Thanks to the communications media and continuing educational programs sponsored by senior citizens' clubs, they now know that Congress can no longer in good conscience deny economic and social

justice to the nation's poor, including the elderly poor, in a Nation with a gross national product approaching a trillion dollars a year—a Nation with the wealth and technical knowledge enabling it to send men to the moon and bring them safely back to earth.

Our seniors are becoming aware that there is no excuse for the rapacious practice in California and in many other States of denying the elderly social security recipients on relief the benefit of the social security increases.

Over 300,000 California seniors have experienced this injustice, thanks to the Governor's veto in 1967 and 1968 of bills which would have corrected this inequity, while he granted additional State tax relief to the oil industry. Surely there can be neither moral, economic, nor political justification for continuing this crime against the elderly poor of our country. By what standard of logic do we allow the Congress to grant needed relief to our elderly, and then permit the State to deny them the right to receive it? Gentlemen, I urge you to stop this "pocket picking."

And I might again pause and indicate that the term "pocket picking" is something we are hearing increasingly, day after day, in reference to this particular injustice.

I urge you to support the proposal presented here last week by Nelson Cruikshank, president of the National Council of Senior Citizens, that no State be permitted to offset social security benefits against old-age assistance payments in any case where the sum of the two is lower than the poverty level determined by the proper Government agency.

The elderly of Southern California, and, I am sure, across the Nation know of the abuses by doctors of the Medicare health insurance program for those 65 or over, and the Medicaid Federal-State health program for the needy—abuses involving millions of dollars, and which are responsible for the recently announced increase for the Medicare Part B (doctor insurance) premium, now \$4 a month and soon to become \$5 a month, the increase in the advance payment required for hospitalization under Medicare from the present \$44 to \$52, effective next January, and the resulting lowering of the quality of care which places an additional economic burden on the elderly poor while enhancing the profits of those who abuse these Government programs.

There is reason to believe that millions of older Americans postpone medical treatment until the crisis stage because they cannot meet skyrocketing doctor fees and hospital charges.

I would like again to deviate from the script, Mr. Chairman, to just make an observation.

I think it would be invaluable to this committee and its members to request a copy of the report issued by Attorney General Thomas Lynch of California in February of this year, dealing with the abuses of the medicare and Medi-Cal programs.

For those who are not acquainted with that term, "Medi-Cal" is the medicaid program under the California law.

This is a 75-page report totally comprised of abuses of these two programs, and I think it would be worthy of the committee's time to review that.

Fortunately, and in spite of a lot of opposition, this year the California Legislature enacted two small pieces of legislation, one which prohibits the conflict of interest by vendors of services or products or medication under the medicaid program, and the other, which I think makes it a crime to submit false information relating to the handling of medicaid cases.

Economists on a task force that studied the health aspects of the economics of aging recently reported to the U.S. Senate Special Committee on Aging:

Health care expenditures represent a major element in the ability of the elderly to maintain themselves financially. Many of the elderly, even with Medicare, are driven from a status of economic independence into dependency and must turn to Medicaid (the Federal-State health program for the needy). Improvement of the plight of the elderly calls for major improvement in income maintenance programs combined with augmented health benefits.

On behalf of the senior citizens of southern California, I ask that Congress place reasonable controls on doctor fees and hospital charges paid for with Federal funds.

Abuses of California's Medi-Cal program, the State version of medicaid, cry out for correction. There was testimony by responsible witnesses before the U.S. Senate Special Committee on Aging hearing in Los Angeles last year that 1,000 doctors were collecting as much as \$70,000 a year treating Medi-Cal patients, and that some were collecting as much as \$100,000 a year under this program.

Governmental controls on what doctors can charge for services paid for by the Medi-Cal program is a necessity.

Surely the honest doctors—there are many, and I honor them—should seek governmental controls, since voluntary control of doctor fees under medicare and medicaid has been so ineffective.

The distinguished members of this committee must have extensive information on how some doctors have used medicare and medicaid to enrich themselves at the expense of the needy. I shall not go into the revolting details brought out at congressional and State inquiries into this critical situation.

On behalf of the southern California elderly, I urge the Ways and Means Committee to impose reasonable rules for the expenditure of medicare and medicaid funds to guard against the demonstrated greed of some medical practitioners.

At the same time, I urge Congress to order the Department of Health, Education, and Welfare to provide incentives that will give medicare and medicaid beneficiaries adequate health care, efficiently and economically.

And, on the subject of hospital efficiency, I suggest that the doctor has a very important role here. The doctor is the one who decides whether a patient shall be hospitalized, for how long, and what hospital services are needed.

In southern California, and, I am sure, in other areas, medicare and medicaid have revealed the alarming inadequacy of today's fee-for-services health care system.

I strongly favor adequate compensation for doctors, but I think there is something wrong with the situation in which the net income of physicians, as I am reliably informed, approximates \$40,000 a year and has been increasing by 10 percent a year, while the average annual pay of employees in community hospitals is \$4,900 a year, and has

risen only 35 percent since 1963. Yet, all too often, the rise in pay of hospital employees has been blamed for soaring hospital costs that in some areas now exceed \$100 a day for a hospital room.

With your permission, Mr. Chairman, I again would like to desert the script and indicate to you that in October of 1968 the Senate Special Committee on Aging conducted a hearing at the State Building in Los Angeles, dealing with increasing medical costs.

As I recall, Senator Harrison Williams and a couple of members of his committee were there. Even then there was established, not by testimony, but by the documentation of doctors' bills and hospital bills and particularly with hospital bills, substantial evidence that at that point in three particular instances hospital services, exclusive of any doctor services, exclusive of any X-rays or tests, was \$103 a day.

I submit, Mr. Chairman and other distinguished committee members, that the rickety fee-for-service health care system—which boasts some of the world's finest doctors and hospitals, but subjects millions of poor, disabled, and elderly to disgraceful care, as representatives of the American Public Health Association testified this week before the Senate Committee on Nutrition and Human Needs—is failing and must be reorganized in the public interest.

Today's seniors are becoming aware that a third of their number are impoverished and lack decent incomes and decent health care.

Today's seniors have read Ralph Nader's statement that 25 to 30 percent of the total productive output of the pet food industry is purchased for human consumption by the poor, and that millions of these purchasers are elderly recipients of inadequate social security benefits.

Here again, Mr. Chairman, I would like to stray from the script and indicate to you that in correspondence which I have in my possession from the Department of Agriculture of the State of California, and from the U.S. Department of Agriculture Consumer and Marketing Service, compliance staff, there is information which indicates that in 1968 General Foods Corporation and one other organization, I think the National Canning Company of Chicago, conducted a survey which disclosed without any equivocation substantiating support for this argument that 25 to 30 percent of the pet food industry's productivity is going into sale for human consumption.

And I am informed by the Department of Agriculture's west coast compliance officer that copies of this document are probably in the possession of the Department of Agriculture here in Washington. He has been endeavoring to get copies of it for me. Up to now I have not heard from him, but I would respectfully suggest that the committee might be interested in obtaining from the Department of Agriculture that documentation.

Mr. CORMAN. Mr. Carbray, without objection, I think those letters should be printed in full at the conclusion of your statement, because they would be useful to the committee.

Mr. CARBRAY. One other thing I would like to go back to is the attitude that is being expressed by senior citizens today.

Today's enlightened senior citizens are neither enchanted nor impressed by the out-dated partisan political approach to our social and economic problems. Age and personal experience have exposed the fallacy of blind and unquestioned party loyalty.

Again, Mr. Chairman, I would like to pause and indicate that this is the attitude that is reflected in meeting after meeting after meeting.

They scrutinize today the voting records of their elected representatives. They get factual information on legislation, which we provide our members, and they are becoming impatient. They want future generations of seniors to enjoy a greater share of our country's economic, social, and cultural assets than they themselves have shared.

Our seniors were not exactly heartened by the recent concern for their own economic security shown by Members of Congress in providing for themselves and members of the executive branch of our Government substantial "cost of living" salary increases and a more generous pension program, without recorded debate as to the availability of funds to cover the cost of the benefits.

Surely Congress would not deny our elderly the right to expect a similar expression of concern for their problems, which are primarily related to inadequate income.

Gentlemen, I respectfully urge you to provide amendments to the Social Security Act which are commensurate with the economic and social needs of our elderly, and which assure them a greater degree of dignity—as the Gilbert bill, H.R. 14430—would do.

In closing, Mr. Chairman, I would like to just make one observation. The other night, Friday night I think it was, October 31, the President of the United States in a speech to the Inter-American Press Association said, and I quote :

If peace and freedom are to endure in the world, there is no task more urgent than lifting the hungry and the helpless and putting flesh on the dreams of those who yearn for a better life.

I pray Congress and the President will apply this principle literally in their deliberations on our domestic problems, and particularly those relating to the problems of the elderly American.

Thank you very much.

(The letters referred to follow :)

CALIFORNIA DEPARTMENT OF AGRICULTURE,
Sacramento, August 27, 1969.

MR. JAMES CARBRAY,
Executive Board Member, National Council of Senior Citizens, Inc., Whittier, Calif.

DEAR MR. CARBRAY: Thank you for your letter of August 18. Mr. Warren Olney of CBS Sacramento is correct. We in the California Department of Agriculture are deeply concerned about the problem of pet food being purchased and eaten by the poor.

Surveys which brought this problem to light were conducted last year by two large national firms which manufacture and sell pet food: General Foods Incorporated in Philadelphia, and the National Canning Corporation in Chicago. According to our information, those surveys indicated that from 25 to 30 percent of canned pet food sold by those two firms is consumed by human beings. You may be able to obtain copies of the surveys by writing to Mr. Don Hill, Officer in Charge, Compliance, U.S. Department of Agriculture, Post Office Box 386, San Francisco 94080.

The California Department of Agriculture carries on one of the nation's strongest state meat inspection programs, in cooperation with the U.S. Department of Agriculture. In 1968, California adopted stricter regulations on the movement of dead, dying, disabled and diseased animals, because it was found that some meat from such "4-D" animals was going into meat locker plants for human consumption and into pet food. It is now illegal to use such meat in pet food manufactured in California, but many other states still do not prohibit it.

Shipments of illegal meat and meat by-products coming into California from other states are being seized by state meat inspectors, and legislation now before

the Governor for signature is designed to further tighten the Department's control over such unwholesome meat.

We continually urge that consumers buy only that meat which bears a certification stamp "U.S. Inspected and Passed" or "California State-Inspected and Passed," or in the case of ground meat, purchase it only from dealers who handle nothing but meat inspected by state or federal officials.

Our meat inspection people work very hard to assure that the people of California can purchase wholesome meat at all times, but consumers, too, must be alert to avoid buying substandard meat.

Perhaps it would help many older people with fixed incomes who have to economize on their meat purchases to obtain help from state and county extension service personnel, who have much dietary information available and are always ready to help people with menu planning.

If we can provide other help or information for you at any time, please feel free to call on us.

Sincerely,

SIMON NATHENSON,
Information Officer.

U.S. DEPARTMENT OF AGRICULTURE,
CONSUMER AND MARKETING SERVICE,
South San Francisco, Calif., September 4, 1969.

JAMES CARBRAY,
Whittier, Calif.

DEAR SIR: Your letter dated August 30, 1969 was received today. We do not have copies of either report mentioned in your letter.

We have forwarded a copy of your letter to our Washington, D.C. office. It is possible they may be of some assistance to you.

We are very sorry that we are unable to comply with your request.

Sincerely yours,

DONALD D. HILL, *Officer in Charge.*

CALIFORNIA LEGISLATURE, SENATE,
September 11, 1969.

MR. JAMES CARBRAY,
*National Council of Senior Citizens,
Whittier, Calif.*

DEAR MR. CARBRAY: I regret and apologize for being late in answering your letter of August 18, 1969 but the responsibility of the State Senate and my district office has required giving priority to letters within my district before answering those outside my district.

You have asked to receive any substantive information or additional reliable sources of information that I might have concerning the fact that pet food is purchased and consumed by persons in the low income brackets, as well as by animals.

By profession, I am a Doctor of Veterinary Medicine and I based my statements in the interview with Mr. Warren Olney, a CBS reporter, on my own personal experience. I have had the experience of using large volumes of pet foods in my animal hospital and have had a distribution system and franchise for some pet foods processed and packaged in the County of Kern located in the San Joaquin Valley of the State of California. This county is a large one, containing 8000 square miles, whose major industry is agriculture and has large numbers of agricultural farm workers who are in the low income brackets. My information is first-hand; observed by myself, and not obtained from any other source.

If I can be of any further help in supplying information to you, please feel free to call upon me.

With my best regards, I remain,

Sincerely,

WALTER W. STIERN, *State Senator.*

Mr. CORMAN. Thank you very much, Mr. Carbray, for a very comprehensive and helpful statement.

Let me ask what you would anticipate would be the reaction of the Governor of California if this committee raises social security, but

does not require a pass-through to the elderly who are receiving both social security and public assistance?

Mr. CARBRAY. Well, I think he is quite a stickler for uniformity.

Let me say that in 1967 he vetoed a bill that was introduced I think at that time by State Senator Teale, which would have eliminated this discriminatory reduction in old age assistance checks, and in 1968 he did likewise, and I recall that one was assembly bill 25. This year, assembly bill 97, which was introduced and which would have served the same purpose was not passed on to the Governor's desk.

I have to assume from past performances that unless something is done on the national level to deprive the State of that right, we are still going to be confronted with this kind of problem.

I think it is reasonable to assume that in spite of the fact, Mr. Chairman, that next year is an election year, that he would hold to his uniformity of policy on this particular issue.

Mr. CORMAN. I thank you very much. That is something that this committee must carefully consider if we are going to take care of the poorest of the social security recipients. Let me ask if you have any personal knowledge of the efficacy of extended care facilities, that level of care which is lesser than the hospital but is to give some medical care to medicaid and medicare recipients?

Mr. CARBRAY. Let me say, Mr. Chairman that I was rather disappointed this year. There was a piece of legislation that was introduced in the State of California that would have provided for State licensing of the operators of nursing homes, extended care centers.

Strangely enough, it never got through the lower house where it was introduced. Our California commission on aging made no recommendation for this, and this was done, I think, primarily as a means of trying to lift the quality of care and there has been a terrific amount of criticism with regard to the quality of care in some of our nursing homes.

I think that we will all recall that sometime in June the Secretary of Health, Education, and Welfare sent out some new regulations dealing specifically with extended care facilities.

Where prior to the time of his decree it was mandatory that a registered nurse be on the premises at a given time during each day, this is no longer necessary as a result of a change which obviously was an economy move of some kind. This has resulted, I am sure, in a further downgrading of what was already a substandard quality of care.

Some of the greatest complaints that the senior citizens organizations are receiving deal with extended care facilities: No. 1, the quality of care, No. 2 the quality of food, and No. 3 the cost factor.

This is one of the reasons, Mr. Chairman, that the report by Attorney General Lynch could be very, very profitable to this committee, the one that I recommended they solicit, because here is considerable space devoted to the nursing home problem.

I am reminded that registered nurses are now mandatory only on the day shift at a nursing home as the result of the Secretary's edict of June which means that for 16 of the 24 hours of the day there is no registered nurse available on these premises which within itself, must provide nothing other than a further downgrading of substandard care.

I had hoped and I would hope that this committee will submit to the Congress a set of guidelines—well, I think I will withdraw that

word "guidelines" because this has been abused—a set of affirmative and definite regulations relating to the operation of extended care centers under medicare and medicaid.

I think it is necessary if we are going to maintain any quality of care that is worthy of being extended to a human being.

Mr. CORMAN. It is my understanding that there are some additional Federal requirements as of July 1, 1970. We ought to take a look at those.

Mr. CARBRAY. I think so.

Mr. CORMAN. Isn't it true that for a great number of elderly, when they no longer have to have hospital care, there is a great need for some intermediate care before they are moved back into their homes and frequently left to their own devices to care for themselves? So that it does seem to me that there is great need for that intermediate care.

The problem is how do we provide it?

Mr. CARBRAY. Well, I recall seeing an article not too long ago with regard to boarding home care for this intermediate service and this seems to be a private arrangement operated privately by people. There is nothing new or strange about this because in the State of California, Mr. Chairman, at the present time in the metropolitan area of Los Angeles there is number of these boarding homes care centers for the juvenile delinquent girls and boys and this would provide the same kind of a functional operation for senior citizens.

I think unless the community, the State or the Federal Government provides for the establishment and, of course, the appropriate licensing which is important, very important, and to assure a quality of care that is befitting a human, unless they provide the money, I doubt seriously if it would attract too much attention, because I think that the profits have become so great in the field of acknowledged nursing home care that some of them now are becoming regular conglomerates within themselves, the nursing home projects, and, unless there is some incentive given for the establishment of this kind of intermediate care, through the form of grants or something of this nature, I doubt seriously if it will ever be a success.

Mr. CORMAN. The 1967 amendment added Federal financing for intermediate care facilities. I understand that is one level below the extended care facility. Are you aware of any that have been constructed?

Mr. CARBRAY. I don't know of a one that has been constructed in the southern part of California.

Mr. CORMAN. I am not aware of it either. If you happen to run across any I would be very interested to know.

Mr. CARBRAY. I will tell you what I will do, Mr. Chairman. I will go to work on it as soon as I go back and whatever I can garner in the form of information, I will be only too happy to forward to you.

Mr. CORMAN. Thank you, Mr. Carbray. I am going to send for attorney general Lynch's report and make it available to my colleagues on this committee. I have heard of it but I have not studied it.

I know that it discloses some facts that we must bear in mind.

Mr. CARBRAY. I, Mr. Chairman, would have brought one along had my notice of this hearing not been so short, because I had one loaned out, but it meant driving to Fresno to get it.

Mr. CORMAN. I am pleased to note that the staff already has the study so that it is in the proper hands at the moment.

Mr. CARBRAY. I provided a half dozen copies, I think, for Senator Harrison Williams' committee while they were in hearing on the west coast and I am sure that there are some around some place.

Mr. CORMAN. Again, thank you very much, Mr. Carbray.

The committee stands adjourned until 10 a.m. tomorrow morning.
(Whereupon, at 4 p.m. the committee adjourned, to reconvene at 10 a.m., Thursday, November 6, 1969.)

SOCIAL SECURITY AND WELFARE PROPOSALS

THURSDAY, NOVEMBER 6, 1969

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The committee met at 10 a.m., pursuant to notice, in the committee room, Longworth House Office Building, Hon. Wilbur D. Mills (chairman of the committee) presiding.

The CHAIRMAN. The committee will please be in order.

Our first witness this morning is Mr. Biemiller, the Director of the Department of Legislation of the American Federation of Labor and Congress of Industrial Organizations.

We appreciate having you back with us again this morning. You have been before the committee on many occasions as well as having served with us in the House at one time. We are pleased to welcome you.

You are recognized.

STATEMENT OF ANDREW J. BIEMILLER, DIRECTOR, LEGISLATIVE DEPARTMENT, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS; ACCOMPANIED BY BERT SEIDMAN, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AFL-CIO

Mr. BIEMILLER. Thank you, Mr. Chairman.

I am accompanied by Mr. Bert Seidman, Director of the Department of Social Security, of the AFL-CIO.

We appreciate very much the opportunity to convey to this committee the views of the American Federal of Labor and Congress of Industrial Organizations on the very important questions relating to social security, public welfare and related matters you are considering. But before outlining our specific recommendations, I would like to place the various problems in their total context.

This committee has it within its power to recommend to the Congress this year legislation which could help to move this Nation far toward achieving an age-old goal of mankind, the elimination of poverty.

We in the labor movement are not johnny-come-latelys to the fight against poverty. This has been our reason for being since the very inception of trade unions. Our continuing concern with the most disadvantaged Americans was most recently evidenced in a series of resolutions adopted by the AFL-CIO convention held just last month. Among them was a resolution entitled "Eliminating Poverty" which I have appended to our statement.

Your committee has been concerned for a long time with plight of the elderly, the disabled and the poor and some of the most important programs designed to improve their conditions. In the light of this long practical experience, I think you will agree with me, Mr. Chairman, that this Nation has never known a time when there was as much ferment about the persistence of poverty and as much hope for its elimination. It is this unprecedented tremendous degree of public concern which has created the potential for fundamental and lasting progress.

Credit also should be given to the administration for again directing the attention of the Nation to the existence of poverty and for suggesting ways of dealing with the problem which, though neither adequate nor entirely appropriate, have stimulated fundamental reconsideration of existing policies and programs.

Mr. Chairman, we in the labor movement are convinced that since poverty has many causes, it must also have many solutions. We do not share the views of those who in a rather simplistic fashion would have us believe that a single program—the negative income tax, the family allowance or whatever—is the panacea which, if adopted, would wipe out poverty in America. Instead, we believe that we need many programs to meet the needs of the many different groups of the poor whose poverty is caused by many quite different factors.

Our approach rests on two fundamental principles which are not always sufficiently recognized.

First, it is more important to prevent poverty before it occurs than to alleviate it after people become poor. This makes completely inappropriate the measurement of the “effectiveness” of social programs solely by the numbers of people they lift out of poverty. It is fundamentally necessary to remove people already poor from poverty. But we must not forget the equally important programs which keep large numbers of people from falling below the poverty line.

Because it is so widely used for so many purposes, let me digress for a moment to comment on the poverty line. I am sure you will agree, Mr. Chairman, that the statistical concept of a poverty level is, at best, inexact and somewhat arbitrary. According to the official government figures, a family of four was poor last year if it had an income of less than \$3.553. Taking account only of the increase in the cost of living, that figure would be higher today. It is based, as you know, on the economy food plan of the Department of Agriculture which is intended for temporary emergency use. Moreover, it calls for purchasing and meal planning skills possessed by few housewives of any income. According to the Department of Agriculture, only a fourth of families who spend the amount permitted by its emergency food plan have a nutritionally adequate diet.

Thus, the official government poverty level is really a minimum level. We can certainly establish no lesser goal than to raise all Americans now living below that line to at least that minimum level and to keep those above it from slipping below that danger line for even tolerable human well-being.

The second principle is that while there are some people who can't or shouldn't work, most people can avoid poverty if the breadwinner in their family has an adequate opportunity for a decent job

at decent pay. The most important aspect of the fight against poverty is the creation of job opportunities at adequate wages for millions of unemployed and underemployed Americans.

Those jobs should be in private employment to the extent that they are available. But to the extent that they are not, then the Government must be the employer of last resort. This is the crucial element which is completely lacking from the administration's proposals. They would do nothing to create jobs for those who are jobless or working at dead end jobs and they would do nothing to raise the wages of the working poor.

Some people have the idea that most of the poor have inadequate incomes because they are lazy and want to be idle. This is an erroneous but widely held misconception. The fact is that two-thirds of the poor are in families where the breadwinner is working, or is jobless, but would work if he could find employment. Indeed, fully one-third of the poor—more than 8 million men, women, and children—are in families headed by someone who works year round. These are the working poor whose substandard wages keep them and their families in poverty.

For the two out of three families headed by someone who is unemployed, underemployed, or underpaid, the road out of poverty lies in suitable jobs and decent wages. This means a national commitment to full employment. What alarms us about the administration's position is its apparent willingness to accept unemployment percentages of 4, 4½, and perhaps even higher. The administration apparently bases its welfare reform and manpower proposals on the naive assumption that jobs will be available in the private economy. This utter inconsistency in the administration's policy can only worsen the situation.

To supplement and make fully effective the national commitment to full employment we need comprehensive manpower and training programs, including a large-scale public-service employment program providing well-planned useful jobs paying at least the statutory minimum wage. And to lift millions of the working poor out of poverty, the coverage of the Fair Labor Standards Act should be universal and the minimum wage should be raised to at least \$2 an hour.

As important as they are, however, neither full employment nor adequate wages are the full answer to the problem of poverty in America. They will not remove from poverty the poor who are young or old or sick or disabled or have family responsibilities keeping them at home. Others are in such large families that a job for the breadwinner at even an adequate minimum wage will not meet the family's needs. For these groups the answer lies in greatly improving, strengthening, and modernizing our social insurance and public welfare programs.

In your recent hearing, we have already presented our recommendations on unemployment insurance. We now wish to give you our recommendations for social security, public welfare, medicare, and medicaid.

SOCIAL SECURITY IMPROVEMENTS

I wish to make clear from the outset, Mr. Chairman, though it is my intention to point out some of the main inadequacies of the Old Age, Survivors, Disability and Health Insurance System, we are fully aware of the great contributions that have been made by it. It is a tremendously successful program which, in a little more than 30 years, has been a major force in improving the quality of life in America. Millions of people who would otherwise be among our most economically vulnerable groups—have been provided regular incomes, and the aged, have been provided medical care, as a matter of right.

So when organized labor points out some defects of the social security system, it is because we want it to fulfill its potential of providing economic security with dignity for victims of death, disability and old age.

Thirty-five years ago a Cabinet committee reporting to President Roosevelt stated that the program of economic security "must have as its primary aim the assurance of an adequate income to each human being in childhood, youth, middle age or old age—in sickness or in health. It must provide safeguards against all of the hazards leading to destitution or dependency." The original Social Security Act of 1935 expressed a similar purpose.

Our Nation has a Gross National Product approaching \$1 trillion. But we have not achieved the goals we set for ourselves as national policy in 1935 when the GNP was less than \$73 billion. The unpleasant truth is that social security benefits, which should be a main bulwark against poverty, have not been adequate at any time in the history of the program.

The Congress has an excellent opportunity to correct the major inadequacies of the system. Pending before this committee is H.R. 14430, introduced by Congressman Jacob Gilbert, which embodies most of the proposals for social security reform advocated by the AFL-CIO. This bill recognizes that a fully adequate social security program cannot be achieved by periodic tinkering with the system. What is needed is a planned program of bold, imaginative reform. H.R. 14430 calls for a 50 percent increase in total benefits over the next 2 years, plus other urgently needed improvements. The AFL-CIO commends this bill to you as a blueprint for achieving in the next few years a social security system worthy of a dynamic, confident America.

One thing is obvious: the administration's proposed 10-percent increase in benefits is totally inadequate. In February 1968, the month for which the last benefit increase was effective, the consumer price index was 119.0. By September 1969, the latest month for which CPI data is available, the index was 129.3, an 8.7 percent rise in a year and a half. Since the effective date in the administration bill, H.R. 14080 is March of next year, with first benefits paid in April, a 10-percent increase would certainly be less than the rise in living costs since February 1968. In other words, the administration proposal would retrogress from the already inadequate level of social security protection afforded by the 1967 amendments.

Mr. Chairman, I would like to document how bad the situation really is. The Senate Special Committee on Aging issued an excellent report this year entitled the "Economics of Aging." This report provides a

graphic picture of the plight of our aged population. I would like to cite a few statistics from that report:

"Median income of aged families was 51 percent of that of younger families in 1961, but had declined to 46 percent by 1967.

That decline is continuing.

"One in nine younger people was living in poverty in 1966, in contrast to a ratio of three out of 10 people 65 and older.

"Another 10 percent of the aged are on the borderline of poverty.

"About half the families headed by an aged person had less than \$4,000 income in 1967 and about 20 percent were below \$2,000.

"In 1967, of older people living alone or with nonrelatives, 50 percent had incomes below \$1,480 and 25 percent had less than \$1,000.

"The Bureau of Labor Statistics retired couple's budget, which defines the amount of income required for a modest but adequate standard of living, is beyond reach of most older people. In 1950, the average social security benefit of a retiring couple was equal to half the BLS budget.

Today it is less than one-third."

It is no wonder the report observed: Facing what must be recognized as a worsening retirement income crisis, the Nation must take positive, comprehensive actions going far beyond those taken within recent years.

In view of the need, we were greatly disappointed by the President's proposal to increase social security benefits by only 10 percent. The average monthly social security benefit for a single retired worker is about \$100 a month; for the spouse about \$52; and for 2.5 million widows about \$87. In the face of these facts, a 10-percent increase would leave the elderly worse off than 2 years ago.

We urge an immediate 20-percent increase as a first step to be followed by an additional 20 percent in 2 years. This is an essential part of a planned program to make our social security system fully adequate. It would lift the burden of poverty from our elderly population and provide them a decent, comfortable living in their retirement years.

COST OF LIVING ADJUSTMENT

The administration included a provision in its social security proposal which would raise, beginning with 1971, benefits geared to the Consumer Price Index. Reliance on such an escalator as the primary mechanism for increasing benefits, when millions of the elderly are living in poverty with the majority of others receiving woefully inadequate benefits, would perpetually condemn them all to a substandard way of life.

Social security beneficiaries have the right to maintain the real value of their benefits in the face of rising living costs as well as to participate in the Nation's increasing standard of living. After all, the elderly in their productive years helped to make possible that standard of living. A more appropriate basis on which to adjust benefits would be in accordance with increases in wage levels.

A cost of living mechanism at this time would be a forward step only if there is clear public policy that benefits will be adjusted upward periodically, in addition to any increases due to the cost of living. This would assure social security beneficiaries a share in the improved living standards of the rest of the population.

EARNINGS BASE

The administration has recommended an increase in the social security earnings base from the present \$7,800 to \$9,000. It is a modest proposal, which does not remedy the deterioration that over the years has been particularly unfair to above-average wage earners. The \$3,000 earnings base, effective in 1938, covered all of the earnings of 97 percent of those in the program. The increases in the earnings base enacted recently have not kept pace with rising wages. The result is many workers receive benefits based on only part of their earnings. In addition, if the earnings base does not rise as rapidly as earnings, the social security tax has to be higher in order to finance benefits based on a decreasing proportion of the national payroll.

For this reason, the AFL-CIO advocates increasing the earnings base by steps to \$15,000 so that for the first time in any years, the overwhelming majority of workers will have social insurance protection calculated by reference to their entire earnings.

We also urge automatic adjustments in the base to keep it up-to-date with future increases in earning levels. We note with pleasure the administration concurs in this proposal.

INCREASES IN WIDOWS BENEFITS

We support the administration's proposal to increase widow's benefits from 82½ percent to 100 percent of the primary benefit. Six out of every 10 aged women living alone have incomes below the poverty line—only \$1,600 for a single person. The Nation's very oldest women are especially disadvantaged. At the end of 1967, the number of widows getting monthly benefits of \$44 or less was twice as high for those age 85 and over as for those under 70 years. As an antipoverty measure, an increase in the widow's benefits to a full 100 percent would do more to help the impoverished per dollar of cost, than probably any other improvement that could be made in the system.

UNIFORM METHOD OF COMPUTING BENEFITS FOR MEN AND WOMEN

We endorse the administration's proposal that the period of years used in computing a worker's average wage should end at age 62 for men, as it now does for women. This change would help those men, who because of ill health or inability to secure employment, retire early on reduced benefits.

RETIREMENT TEST

The administration's proposal would liberalize the retirement test by raising the earnings exemption from \$1,680 to \$1,800. It would replace the present dollar-for-dollar reduction in benefits, which now applies for earnings above \$2,880, with a \$1 reduction for each \$2 earned, which would be updated periodically in accordance with increases in earnings. Though the AFL-CIO has long opposed total elimination of the retirement test, the proposed liberalization is basically an adjustment for the increase in wages since the \$1,680 exemption was adopted. For that reason we do not oppose it.

OTHER SOCIAL SECURITY PROPOSALS RECOMMENDED BY ADMINISTRATION

The administration is also proposing an adjustment in the formula for determining the maximum family benefit. The present formula provides for a maximum of 80 percent of the worker's average monthly earnings up to two-thirds of the wage base plus 40 percent of the average monthly earnings in excess of that amount. Under the administration's proposal, the 80 percent maximum applies only up to the point at which the average monthly earnings amount is one-half (but not less than \$450) rather than two-thirds of the wage base. Reference to an 80 percent maximum is misleading since the average wage to which it applies must be computed over a working lifetime and will include low wage base levels of earlier years. These average earnings bear little relationship to actual earnings at time of death or disability and most families suffer a severe decline in living standards when the main breadwinner dies or is incapacitated. A \$450 cut-off point is too low and will make no real contribution to the resolution of this social problem. We urge retention of the present formula and its application to a \$9,000 wage base.

The administration proposes a number of their changes in the social security law which we support. One would continue disability benefits to individuals disabled since childhood to age 22, rather than age 18, as under present law. The second would pay benefits to the aged dependent parents of retired or disabled workers, now payable only to dependent parents of deceased workers. The third would extend the \$100-a-month noncontributory wage credit for military service for the period from 1957 to 1967, in the same manner as the 1967 Social Security Amendments provided for military service after 1967. Basically, these changes would simply provide greater uniformity of treatment for the respective categories involved, and, though only minor in terms of cost and impact on the system, would be of vital importance to those affected by them. We urge their passage.

Unfortunately, the administration did not make any suggestions for dealing with some of the most difficult and pressing problems faced by other social security beneficiaries. I would now like to comment on some of these.

MINIMUM BENEFIT

Of all our many disappointments concerning the administration's proposals, the most disappointing one was failure to substantially raise minimum benefits.

It is a sad fact that almost one-third of all Americans aged 65 or over are in poverty. It is particularly shocking that the number of impoverished older people is increasing, while the number of people under 65, who are below the poverty line, is steadily decreasing.

The social security system can and should play a greater role in the elimination of poverty. Since the major source of continuing income for our elderly is the social security benefit, it is the primary determinant of their economic status. For this reason, the AFL-CIO has given social security improvements a major priority in its legislative program and has emphasized an increase in the minimum benefit as an antipoverty weapon.

We urge at least a first-step minimum benefit increase to \$90 (\$135 for a couple), to be followed by an increase in 2 years to \$120 (\$180

for a couple). This would be a notable advance toward assuring the poorest retired Americans a significant measure of income which they would receive as a matter of right, based at least partly on their own contributions.

The savings in welfare costs made possible by a decent social security minimum could substantially help meet the costs of an adequate social security system.

The shift of recipients from welfare rolls to social security has been in process since the latter program's inception. Since that time, the percentage of the elderly receiving old-age assistance has been reduced by more than one-half. A \$90 minimum would go a long way toward completing the process.

DISABILITY AND RETIREMENT

The impact of automation and other technological structural changes on employment in recent years have created serious problems for the older worker, who is not yet 65, and, therefore, ineligible for full social security benefits. A number of changes should be made in the Social Security Act to meet more effectively the interrelated problems of old age, disability and unemployment.

We urge adoption of an occupational definition of disability for older workers, so that any disabled worker after age 50 or 55, who is unable to handle his usual occupation, would be entitled to social security disability benefits. Many such older workers, who are no longer able to perform their regular job and find it almost impossible to secure other employment, cannot meet the stringent definition of disability now in the law. An occupational definition of disability is essential to help resolve the plight of these older workers made jobless by physical impairment.

This change, coupled with a more adequate benefit structure and a less than full actuarial reduction for those who choose early retirement under social security would, in effect, establish a flexible zone of retirement for older workers. This would allow an individual a greater retirement choice by recognizing that the appropriate retirement age varies with his financial situation and with physiological and occupational characteristics, and with labor market conditions.

Another way to mitigate the problem would be to increase the number of dropout years in the benefit formula as a first step toward a formula based on the high 5 or 10 years of earnings. Presently, the social security law allows dropping out 5 years of low or no earnings in computing a worker's benefit. This provides only limited protection against unemployment, illness and low earnings. The low wage bases of earlier years result in the typical worker receiving benefits little related to his earnings just prior to retirement. For older workers who are victims of unemployment and ill health, the problem is much more acute, since they must include additional years of low or zero earnings in determining their average monthly wage.

We also urge some improvements in the basic disability insurance provisions. Under present law, benefits for disabled widows are limited to those over age 50, and at that age are only 50 percent of the deceased worker's primary benefit. There seems to be little reason for these restrictions and the cost of their elimination would be negligible. Any disabled widow should receive the full widow's benefit.

In addition, under present law, benefits are not paid unless total disability lasts 6 months, is totally incapacitating and is expected to last at least 12 months or result in death. Many workers are incapacitated for months without either regular income or benefits. This can have a catastrophic impact on a family, causing economic hardship that may last years beyond the breadwinner's return to work. The Social Security Act should be amended to permit benefit payments after 3 months without regard to the expected duration of the disability.

HEALTH INSURANCE FOR THE AGED—MEDICARE

The AFL-CIO profoundly regrets the administration did not make any major recommendations for basic improvements in medicare. Medicare constitutes one of the most important social advances of this decade. It has given our older people health care with dignity and self-respect. But medicare meets only about half the health costs of the elderly. Therefore, it has not achieved comprehensive quality medical care for all elderly Americans. A number of improvements deserve immediate enactment.

PRESCRIPTION DRUGS

Under medicare, prescription drugs are provided to inpatient beneficiaries in hospitals and extended care facilities. But there is no provision to cover prescription drug costs for out-patient beneficiaries—the very drugs which help to keep these people healthy and away from expensive hospital stays.

Since nearly 80 percent of persons aged 65 and over suffer from at least one or more chronic conditions, their requirements for life-sustaining drugs are particularly important. Representing only 10 percent of the population, the elderly use nearly 25 percent of all prescription drugs. Their per capita expenditures for drugs are more than triple of those under age 65. The heavy burden of these expenditures is obvious, when measured against the limited resources available to the elderly to meet such costs and the inadequacy of existing private insurance arrangements to protect against them.

As you will recall, the Senate in 1966 passed a prescription drug program but the House did not agree. In 1967, Congress directed the Secretary of Health, Education, and Welfare to undertake a study of the feasibility of a prescription drug program. He appointed a task force which recommended that the medicare program cover prescription drugs. Upon assuming office, Secretary Finch appointed a committee of experts to study and report to him on this task force recommendation. His committee also recommended that prescription drugs be included in the medicare program and, in fact, urged more extensive coverage of prescription drugs than the original task force. Mr. Chairman, there is no longer any reason for further delay in this matter.

We urge immediate enactment of a prescription drug program.

MEDICARE COVERAGE OF THE DISABLED

The 1½ million disabled social security beneficiaries use, proportionately, seven times as much hospital care as the general population and three times as much physician services. At the same time, the median income of these beneficiaries is less than half that of the non-

disabled population. When unemployed, the severely disabled person is ineligible for group insurance and must rely on more expensive, individual health insurance policies, if they are available to him at all.

In short, all of the reasons for providing health insurance to the elderly apply to the disabled but, if anything, to an even greater degree. They experience a greater incidence of illness, live on low incomes and find it difficult to secure and pay for health care.

The Advisory Council on Health Insurance for the Disabled, appointed pursuant to the 1967 amendments, has recommended coverage of the disabled beneficiaries and we endorse this proposal.

COMBINE HOSPITAL (PART A) AND MEDICAL (PART B) INSURANCE

We urge that both the medical (part B) and hospital (part A) insurance be financed through the contributory social insurance system. Presently part B is voluntary and is financed by enrollees paying monthly premiums equal to one-half the cost of the program and by a matching Federal contribution. Part A, like the rest of the social security program, is financed by contributions during the working life of an individual.

This fragmentation creates serious problems which are made worse by the rapid increase in the monthly premium for part B. The initial \$3 premium for an individual is scheduled to reach in excess of \$5 (more than \$10 for a couple) next year—over a 70 percent increase in less than 4 years. This premium is rapidly becoming an unconscionable financial burden on the elderly and will force those with the most limited means to drop out of the program.

The sensible solution to this problem is to combine parts A and B and provide for financing of medical care during a person's working life in the same manner as the rest of the program. This would remove the burden of paying the monthly premium after retirement when the individual can least afford it. All medicare services should be a matter of earned right, like the rest of the social security program, with this right firmly established through mandatory contributions during working years.

FINANCING OASDHI

H.R. 14430, a bill introduced by Congressman Gilbert of New York, embodies all of the major recommendations we have made today as well as a number of other improvements. This bill provides that the social security system, with the improvements recommended, be financed in four ways:

- (1) Increase the contribution and benefit base to \$15,000 in two steps, with the first increase to \$9,000 to be effective January 1971, and the final step to be effective January 1973, with automatic adjustment of the base.

- (2) Use of the current favorable actuarial surplus of 1.16 percent of taxable payroll.

- (3) Rounding out the presently scheduled contribution rate for each employer and employee from 5.9 percent to 6 percent.

- (4) Gradually increasing the Government contribution from the general revenues to eventually equal approximately one-third of the program's total cost.

This last recommendation we consider essential. A fully adequate social security system would require increases in the contribution rate that would place an unfair burden on low wage workers since the social security contribution considered solely as a tax is regressive. In his testimony before this committee President George Meany in 1967, stated on behalf of the AFL-CIO:

But in all candor I think you should know that in time, we shall urge a modest and gradual contribution to the Social Security Trust Funds from the general revenue of the United States. We believe this would be an effective way—and a simple one—to introduce the principle of progressive taxation to the Social Security System. We are not asking for this now, so I will not argue the case for it. But we will be back.

We now urge this committee to increase the modest amounts of general revenue now going into the social security program as a start toward a tripartite system of financing—one-third employee, one-third employer, and one-third Government. This would effectively introduce the principle of progressive taxation into the social security program and distribute the social security tax burden more nearly in accordance with ability to pay.

Many foreign nations use general revenue to wholly or partially finance their social security systems. But it isn't generally known that general revenue financing has long been contemplated in this country. In fact, the original social security legislation submitted to Congress in 1935 contemplated an eventual Government contribution. The Committee on Economic Security that did the spadework for the Social Security Act actually mentioned 1965 as the likely year when an initial Government contribution might be required. Though a general revenue provision was not in the original legislation, one was included in the Social Security Act from 1944 to 1950. It was removed by the 1950 amendments against the recommendations of the Advisory Council on Social Security.

General revenue funds are already being used to pay for some of the costs of the system—wage credits for military service, hospital insurance benefits for noninsured people, matching the insurance premium of enrollees in the supplementary medical insurance program (part B), and age 72 special benefits.

A general revenue contribution is not a radical new idea but only an old proposal that has never been properly implemented. We urge immediate introduction of a general revenue contribution which should eventually cover one-third of the cost of the program.

MEDICAID

Passage of medicaid committed the Nation to providing health care for all indigent and medically needy Americans. It became an additional source of financing the existing system without disrupting it.

Medicaid experience so far has helped to expose many of the cost-escalating elements of health care in this country. Reaction to this exposure has been twofold; elimination and reduction of services for some and total denial of care to large numbers of others, who need medical care but can't possibly pay for it.

The remedy for uncontrolled medicaid costs is not curtailment of the program, but establishment of reasonable and effective cost controls.

In another part of our testimony, we shall offer specific suggestions for controlling costs.

Currently, only 26 States cover the medically needy.

The Nation's unwillingness to organize its health care system has caused many sick people to suffer from lack of care. Curtailing services by narrowing the definition of the "medically needy," does not enhance their ability to pay the cost of medical care. The first major illness that afflicts such a family, so stringently affects their finances that they become immediately eligible for medical assistance and, in many cases, cash assistance as well. In doing away with the inadequate and inefficient system of charity, medicaid was intended to provide health care to the medically needy who don't quite qualify for public assistance.

Medicaid should serve its original purpose of providing for all people who cannot defray their costs of medical care. Most of these medically indigent people have no insurance protection. Therefore, they must pay for medical care, however expensive it may be, out of their meager incomes.

The harsh fact is, though, that without medicaid, these people simply cannot and do not get necessary medical care, even when they are acutely ill.

There is only one way of meeting this situation at the present time—medicaid must cover the needy and the medically needy.

There is great variation in the scope of medicaid services and treatment from one State to another. Needed, therefore, are comprehensive health services for medicaid recipients in all States.

We recommend Federal administration and financing of medicaid as an essential part of the federalization of the public welfare system. Short of complete federalization, we urge uniform Federal standards for eligibility and scope of services under medicaid.

One year ago, the Advisory Commission on Intergovernmental Relations, a distinguished group of Americans of both parties and representing all levels of government, issued a report after making an exhaustive study of the operation of the medicaid program. In its very first recommendation, the Commission said:

The Commission recommends that Congress and the administration adhere to the goal of comprehensive care for "substantially all" the needy and medically needy established in section 1903(e) of the Social Security Act, and that they, along with the States and localities, take such steps as necessary to move toward that goal.

The Commission further stated that this recommendation should be supplemented by consideration of a national universal health insurance program which the AFL-CIO has long favored. However, the Commission made it clear that longer-term consideration of a more comprehensive program should not detract in any way from progress toward the medicaid goal (then set for 1975 and since postponed until 1977) of comprehensive health care for the needy and medically needy.

We urge the Congress to do everything possible to speed the realization of that goal and to take no restrictive action which could hinder its achievement.

HEALTH CARE EFFECTIVENESS AND COST CONTROLS

We support most of the administration proposals to contain health care costs. We think, however, that the proposed program does not go far enough. In capsule form, the administration bill would:

1. Tie payments for depreciation to State planning under 314(a) of the Public Health Service Act.

2. Require budget planning as a condition of participation in Federal programs.

3. Expand the authority of the Secretary of Health, Education, and Welfare to make experiments related to reimbursement.

4. Expand the authority of the Secretary to withhold reimbursement for services to persons and institutions who abuse Federal health programs.

5. Provide for paying customary charges if less than cost.

6. Strengthen the authority of the Secretary to withhold payments where hospital utilization exceeds professionally determined limits.

7. Expand the authority of the Secretary to recover overpayments.

The main exception we take to this program is that of tying depreciation payments to State health planning. This opposition is not taken lightly. We are philosophically oriented to favor planning as a means of rationally allocating resources.

In most States, planning is just getting underway. Most States are in the fact-gathering stage. The composition as well as the qualifications of the members of the advisory councils to these planning bodies vary widely from State to State. The degree of influence of physicians and of financial interests on the one hand, and of consumers on the other, also varies considerably from one State to another. Therefore, we think it would be inappropriate at this time to give State planning bodies authority to tie payments for depreciation under Federal programs to conformity to a State plan. Therefore, we recommend that the authority of the various State planning bodies be limited to voluntary efforts to achieve compliance with State plans.

The second point of the administration proposal relates to the requirement of budget planning as a condition of participation in medicare, medicaid and other Federal programs. We support this. However, the intent is limited to institutional planning and primarily hospital budget planning.

To contain costs, certain essential principles must be incorporated into any mechanism to finance health services including medicare and medicaid. These principles are:

(1) Benefits must be comprehensive.

(2) There must be continuity of care.

(3) Services must be accessible.

(4) Relationships between those who pay the bills and the providers of care must be contractual.

In general, all people involved in the delivery of health care agree with the first three principles, but many disagree with the fourth. Yet the fourth principle is essential to fully accomplish the first three objectives.

With regard to the first principle that benefits should be comprehensive, partial coverage necessarily distorts the optimum pattern of delivering service. If, for example, hospitalization is the only benefit covered by the program, then the patient can receive a benefit and the physician can only be assured of being paid if the patient is hospitalized. Lower cost alternatives such as outpatient services, nursing home care, home health services and preventive care will be underutilized causing higher total costs. Health care programs should therefore cover the entire spectrum of health services.

The goals of the medicaid program conform to this principle better than medicare although, as we have previously stated, implementation of the medicaid goals by many States leaves much to be desired. Medicare does not cover preventive care or prescription drugs outside the hospital. By extending medicare to cover these benefits patients will get better care and total health care costs will be reduced.

The medicare program requires the separate payment of the hospital and medical practitioner and even excludes from the hospital payment the physicians employed by the hospital. It should provide a single payment mechanism for both hospital and physician services by merging parts A and B of the medicare law. While the Federal medicaid law permits comprehensive payments for comprehensive care, many States have split financing for physicians and hospital services.

The basic principles we have suggested for assuring comprehensive health care are now applied only in comprehensive prepaid group practice plans. Their development should be encouraged instead of hindered—as is all too often true now—under medicare and medicaid.

With regard to expanding the authority of the Secretary of Health, Education, and Welfare to make experiments related to provider reimbursement, what is needed is not just more experiments but applying now what we already know. Relationships between parties that pay for health care on behalf of the public on the one hand, and the providers of care on the other, should, wherever possible, be contractual. The American free enterprise system is built upon contractual relationships between free parties. There is nothing new or startling about this concept.

The prepaid group practice plans have, for years, contracted with medical groups for services for the members of the plan. For example, the Kaiser Foundation health plan contracts with the Permanente medical groups and each medical group assumes the responsibility for delivering health services to members of the plan within the framework of a budget as determined by the contract. The Kaiser plan was studied in depth by the President's Commission on Health Manpower. The Commission concluded that the Kaiser system provided as good or better care than is available under the fee-for-service system at 30 percent less cost.

A contract need not be between the fiscal agent and an organized group practice. For example, the State of California contracted last year with the San Joaquin Medical Foundation, organized by the San Joaquin County Medical Society, to provide medical services to medicaid eligibles. At the end of the year, the foundation turned back \$200,000 to the State. We submit that this is probably the only case in the United States where the cost of medicaid was less than anticipated.

There may be separate contracts with hospitals and physicians, but preference should be given to a single contract for all health services through groups of physicians. This is important because both cost and quality control should be a group responsibility. If one doctor hospitalizes patients too frequently, he is, in effect, reducing the income of other physicians in the group. The San Joaquin plan as well as the prepaid group practice plan also include peer review systems for maintaining quality of care. We, therefore, recommend that the medicare law be amended to provide that fiscal intermediaries be encouraged to contract for health services from the providers and, at a minimum, that contractual arrangements be recognized as an alternate method of re-

imbursement to usual and customary fees. States should be encouraged to do the same thing under medicaid.

With regard to expanding the authority of the Secretary to withhold reimbursement for services to persons and institutions who abuse Federal health programs, we wholeheartedly agree. We also agree that Federal programs should not pay in excess of customary charges to other (nongovernmental) beneficiaries.

We endorse the administration's proposal to strengthen the authority of the Secretary to withhold payments where hospital utilization exceeds professionally determined limits but we submit that for this to be effective hospitals will have to exercise a much greater degree of control over physicians than they now do. The physician, not the hospital administrator, makes the decision to admit a patient to the hospital and when to discharge him. Hospital utilization is "professionally determined" by physicians in the prepaid group practice plans as well as under fee-for-service. This is often why hospital utilization under the prepaid or contract arrangement is about one-half when compared to the fee-for-service system. Under our present fee-for-service system, physicians simply do not have the same financial incentives to control hospital utilization.

Such incentives are necessary, and can be accomplished by providing comprehensive payments for comprehensive services including both inpatient and outpatient services. Short of this, hospitals should be reimbursed by capitation, periodic payments following prior budget approval or on the basis of average payments to all hospitals rendering similar services under comparable circumstances.

We concur in the proposal to expand the authority of the Secretary to recover overpayments.

We have the following additional suggestions for containing medical costs.

1. Medicare and medicaid should require that participating physicians, either through an organized group practice or through their State or local medical societies, establish systems of peer review under which the appropriateness of treatment is judged against the indicated diagnosis in light of current standards of medical practice. Such peer review systems have brought about cost savings as a by-product of quality control. These savings are mainly achieved through a reduction in unnecessary hospitalization and in unnecessary surgery.

2. Negotiated fee schedules are preferable to the usual and customary fees. However, the experience of our negotiated health and welfare funds over two decades has been that it is most difficult to secure the cooperation of physicians in limiting charges to the fee schedule. The option under medicare which allows direct billing of patients makes enforcement of a fee schedule difficult. Also, if physicians are not satisfied with the fee schedule, it is relatively easy for them to increase the number of their services. Nevertheless, if fixed fee schedules were established, it would help to restrain cost escalation. We therefore recommend use of such schedules under medicare and medicaid wherever reimbursement of providers on a contract basis is not in force.

3. Hospital administrators have told us that they control only 10 to 25 percent of the hospital's budget. Nursing assignments, orders for diagnostic and laboratory tests and drug prescriptions are made, in the

typical voluntary hospital, by physicians having no administrative responsibility to the hospital as an organization. It is remarkable, that to our knowledge at least, no study has ever been made as to what percent of the hospital budget is actually under the control of the hospital administrator. We therefore recommend as a condition of reimbursement under Federal programs and in order to control hospital costs that hospitals should be required to employ a full-time medical director and that the various department heads and all hospital-based physicians should be paid by the hospital.

4. Studies show that approximately 20 percent of the hospital's budget for drugs can be saved by establishing a formulary of list of approved drugs for use by the medical staff. We therefore recommend that every hospital should, as a condition for participation in Federal programs, be required to establish a formulary and purchase drugs for this formulary by generic name on a competitive bid basis.

5. An increase in the supply of physicians, dentists, nurses, and allied health professionals is needed if the goal of early access to health services is to be achieved, but it is essential to make more effective use of auxiliary personnel as a means of increasing the productivity of both physicians and dentists. We therefore recommend that the Federal Government should expand present health professions education programs to provide more health profession scholarships and additional funds for student loans. Congress should attach a high priority to the support of experimental projects designed to make more effective use of allied health professionals.

WELFARE REFORM

At the time President Nixon delivered his message on welfare reform, president Meany stated, "The President has forcefully turned the public's attention toward a major problem in America and has established laudable goals for his administration. This in itself merits commendation."

He further stated:

The Welfare Reform message provides for the declaration method of determining eligibility for welfare payments, thus eliminating degrading and time-wasting detailed investigations by local welfare agencies. It would eliminate the cruel requirement practiced in about half the States, that the father must leave his family in order to qualify the mother and children for welfare payments. It provides an expansion, though inadequate, of manpower training for some welfare recipients and day care for their children. We have advocated and endorse these long-overdue steps.

An analysis of the welfare proposal as a whole, however, convinces the AFL-CIO that while the program's aims are laudatory, it represents a far cry from the President's goal of "a full opportunity for every American to share the bounty of this rich land."

The overwhelming majority of underemployed and unemployed Americans do seek the dignity of decent jobs with decent pay. The overwhelming majority of working mothers do seek an end to mounting welfare rolls.

We welcome the opportunity provided by the committee and the administration to discuss new alternatives in the approach to poverty.

It is essential that the whole area of public welfare be put in its proper perspective. No conceivable reform of welfare can solve all our domestic and social ills. Public welfare cannot assume the responsibility of providing education, health, jobs, housing and legal services, or eradicating racial discrimination, or supplying many

other unfilled social needs. In fact, public welfare exists in part because of the failures in other areas to meet human needs.

The primary responsibility of a public welfare system is to get cash into the hands of those unable to provide for themselves. It should be supplemented with an effective supportive service program. The single criterion of eligibility should be "need." It should be federally financed and administered.

The program must be guided by Federal standards so that all needy people in every nook and corner of this country will be treated alike. Even then, to pretend that a public welfare program will resolve all our problems is to raise false hopes.

The administration's welfare reform bill moves in the direction of structural reform. We support many aspects of the proposal as necessary basic changes in the present system. We strongly support the concept of a Federal minimum floor although the level proposed is utterly inadequate. However, at this time when the fiscal integrity of our States is challenged by the many obligations against their treasuries, we think that the threat of withholding funds for medicaid and assistance to the aged, blind and disabled when a State refuses to maintain its present level of payment to AFDC is not a solution to either welfare problems or Federal-State relations.

The administration's proposal will benefit only about 50 percent of the present number of cash recipients. It does so by greatly rewarding many of those States which have done the least for its needy and failing to help adequately those States which have done the most.

Of the 6.5 million people presently receiving AFDC payments, only 1.2 million will receive increased benefits from a Federal minimum of \$1,600 for a family of four. The remaining 5.3 million could remain at their present level indefinitely.

Although we strongly support the principle of a Federal minimum payment, \$1,600 a year for a family of four is grossly inadequate. At present it represents less than 50 percent of the poverty level. Even with the addition of \$750, as the value of food stamps, a family of four would still have to eke out a living at approximately 40 percent below the poverty line.

Because State legislative action is necessary, the proposal would not take effect for a year and a half. Since the proposal makes no provision for periodic updating, a very serious omission which ought to be rectified, the proposed minimum payment will undoubtedly be even more inadequate when it takes effect.

The administration could continue mandatory work and training programs for welfare recipients. Whatever had been the hopes or expectations for WIN, its experience clearly indicates that it has been unable to place people in jobs.

How can people be compelled to take jobs that aren't available to them, or take training programs that aren't yet functioning, or put their children in day care centers that haven't been built? We should provide people with adequate education, provide upgraded training where needed for the underemployed, make jobs available which pay at least the statutory minimum wage, make day care centers available for children of mothers who want to work and make decent health care available to everyone. After all this is done, if we find welfare rolls still expanding with qualified, educated, able-bodied adults while

at that time truly productive good paying jobs go begging, we may then wish to consider whether compulsory work requirements would be desirable.

We reject the fatalistic attitude toward the existence of the working poor that underlies the administration's proposal. Most poor families with an actual or potential employed breadwinner can be lifted from poverty if their wages are at a decent level. If this is done, only the incomes of very large families in which there is only a single employed person working at a minimum wage would still be below the poverty line. Consideration would then have to be given to supplementing the incomes only of such families. But for most of the working poor, the simple solution for poverty is that employers should be required to pay decent wages.

The administration's proposal requires all welfare recipients, except those specifically exempt, to accept "suitable" work or training as determined by the Labor Department. But no criteria are established as to what work or training is "suitable". The Department of Labor already has a precedent for defining suitable work in the unemployment compensation system. Similar criteria should be used for employables now receiving welfare. There should be no referral to jobs paying substandard wages or in which a labor dispute exists. Referrals should be in accordance with the qualifications and any past experience of the individual.

We propose that all other needy persons, including but not restricted to the disabled, the blind, and families with dependent children, should be assured payments based on their need but at least at the poverty level. They should not be held to subpoverty levels of living because some other families can supplement their incomes by working. In addition to adequate incomes, rehabilitation and effective social services should be the basic programs for this group.

The administration's proposal for a \$90 minimum payment for the "adult categories" is a welcome step in this direction. But to be realized it must be federally financed.

We propose for the approximately 2 million OAA recipients, 1.2 million of whom also receive social security benefits, a Federal minimum no lower than the poverty level.

A very unfortunate situation has evolved as a consequence of States reducing their OAA payments with each increase in social security benefits. We, therefore, urge your committee to assure that social security benefit increases will not be offset against OAA payments where the combined payments are less than the official Government poverty level.

The public welfare program should be administered on a decent humane basis recognizing that its participants are dependent disadvantaged Americans who deserve no further punishment, but need help. In this regard, the proposed family assistance plan only indirectly touches upon the most serious omissions in the services offered. HEW itself is moving toward separation of social services from income maintenance on the basis of strong evidence that the combination of services and eligibility investigation is both ineffective and inefficient. The internal realignment of functions can be strengthened and hastened by statutory adjustment which would explicitly separate these two functions.

A high priority must be given to closing the most critical gaps in social services: day care, foster care, adoptions, protective services for children, counseling and guidance to unwed mothers and legal services to the poor.

Day care is an indispensable adjunct to the employment and training of mothers, many of whom have demonstrated a desire to obtain decent-paying jobs. If we are to have any hope of success in the employment and training of mothers, Federal funds now completely lacking must be available for construction of day-care facilities. The day care program must have as its primary emphasis child care and development.

The Federal investment in child protective services, foster care and adoption services is currently miniscule. Financial assistance in this area is needed to bolster the voluntary contributions of the private sector.

Rehabilitation programs must be instituted for those who are not currently capable of entering employment training. The vocational rehabilitation service of HEW has had exceptional success in this area and it should be augmented.

We endorse the recent statements of the American Bar Association, the U.S. Judicial Conference and the National Commission on Violence emphasizing the importance of legal services for the poor. We urge the Congress to continue the programs, without restrictions or inhibitions.

In summary, we are asking that in considering the administration's proposals for welfare reform as well as others that may be offered, your committee recognize both the potentialities for improvement as well as the inherent limitations of public welfare. We urge a federalized public welfare program with payments to those forced to depend on it at no less than the poverty level. For recipients who can work, there must be adequate training for meaningful jobs paying decent wages. For all other needy persons, adequate payment levels should be supplemented by a massive expansion of day care, health, rehabilitative and other supportive services.

As the AFL-CIO executive council said on February 21, 1969, in its statement entitled "Toward Eliminating Poverty," we are well aware that there is no single, simple answer to poverty, but there are solutions. These solutions are to be found in the creation of productive jobs at decent wages, social insurance providing adequate benefits, and a Federal welfare program that brings dignity to its recipients.

Acceptance of the recommendations we have placed before you would mark a signal step toward wiping out poverty in our country. We ask your committee to grasp this opportunity for the betterment of all America.

Thank you for the time you have given us this morning.

The CHAIRMAN. Thank you, Mr. Biemiller, for bringing these views to the committee.

Without objection, the resolution you referred to, appended to your statement, will appear at this point in the record.

(The document referred to follows:)

AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS
POLICY RESOLUTION ON ELIMINATING POVERTY, ADOPTED OCTOBER 1969

Since its inception, the American labor movement has been enlisted in the age-old struggle of mankind against want and deprivation. Unlike many others, trade unionists have not recently rediscovered the existence of poverty in our country. We have known for a long time that millions of people were poor; a very few were our own members, but most were not.

We are not Johnny-come-latelys to the fight against poverty. Organized labor has long had its anti-poverty program—full employment, a better minimum wage for more workers, basic improvements in social insurance, expanded job and training programs and a decent level of public assistance. These were just a few of the anti-poverty demands of the AFL-CIO at our founding Convention in 1955. They are our demands today.

Because we are not newcomers to the fight against poverty, we welcome the sympathetic recognition that problem received under the administration of Presidents Kennedy and Johnson. Under their dynamic leadership, this nation launched a determined effort to wipe out poverty.

We also appreciate the recognition President Nixon has shown, especially in his message on welfare reform. But, however desirable it may be to direct the nation's attention to the problem of poverty, it is not enough, unless there is also effective action aimed at substantially improving the condition of those who have not shared in the nation's prosperity. On this score the President's recommendation for welfare reform does not measure up to the nation's needs.

According to the official government figures, 25 million—one out of every eight men, women and children—are poor. At the government defined poverty line, a family of four has an income of less than \$3,500.

People are poor when their incomes do not permit them to buy even the bare essentials of life. They are poor for many reasons and the impact of poverty is very uneven.

There is a widespread misconception that most of the poor are in need because they are lazy and do not want to work. The facts are just the opposite. Two-thirds of the poor are in families where the breadwinner has a job or is unemployed and would work if he could find a job. One-third of the poor are in families headed by someone working year-round. These are the working poor—the people who are denied decent incomes for the work they do.

There are other facts about the poor which have an important bearing on what can be done to wipe out poverty.

1. Families headed by women are particularly likely to be needy—nearly one in two and they comprise more than one-fourth of all poor families.
2. Most of the poor are white, but the incidence of poverty is much greater among Negroes—one household in three, compared with one in seven for whites.
3. Forty percent of the poor are children and large families are much more likely to be poor than smaller ones.
4. Twenty percent of the poor are elderly. Of the elderly three in ten are poor.
5. Although most of the poor live in urban areas, poverty is twice as prevalent for the farm population.
6. Half of the poor are below the Mason-Dixon Line.

One thing is clear. Just as there are many reasons why people are poor, there must also be many programs for eliminating poverty. Contrary to the claims of some, there is no single panacea.

For the two out of three families which are poor because the breadwinner though employable is unemployed, under-employed or underpaid, suitable jobs and decent wages are the most promising road out of poverty. This calls for a national commitment to full employment with reduction of unemployment to a maximum of 2 to 2½ percent of the labor force. It also calls for comprehensive manpower and training programs including a large-scale public-service employment program providing well-planned useful jobs paying at least the statutory minimum wage. And it calls for raising the minimum wage to at least \$2.00 an hour and extending its protection to all workers, steps which alone would lift 8 million Americans, one-third of the poor, out of poverty.

These manpower training and minimum wage improvements should be buttressed by such supplemental measures as effective enforcement of anti-discrimination laws, as well as housing, health, education, day care, and other social service programs which would not only help lift the poor out of poverty but also better community life for all of us.

But there are some poor people who will not benefit from jobs and minimum wage coverage because they are young or old or sick or disabled or have family responsibilities keeping them at home. Others are in such large families that a job for the breadwinner at the minimum wage or even slightly above does not provide an adequate income. For these groups the answer lies in substantial improvements in social insurance and a greatly improved welfare program.

Eligibility for social insurance—old-age, survivors and disability insurance, unemployment insurance, and workmen's compensation—is a right workers earn during their previous employment. But far too many people who depend on social insurance payments are poor. With expanded coverage and higher payments, social insurance could remove millions from poverty. This requires federalization, or at least federal minimum standards, in the unemployment insurance and workmen's compensation programs and a 50 percent increase and a \$100 minimum benefit plus other needed improvements in Social Security.

Job and training, the minimum wage and social insurance—these are the programs which, if substantially improved, could wipe out much of the nation's poverty. But even these programs do not offer a total solution of our poverty problems. They will not meet the needs of some of the poor, including mothers and children in fatherless families, families of workers who are unemployed, underemployed, or unemployable but not entitled to adequate social insurance payments and large families with relatively low-paid wage earners. For these people, we need a compassionate and greatly improved public welfare program.

Unfortunately, despite what may be good intentions, the President's welfare reform proposal does not meet this need. The Administration would provide a \$1,600 welfare payment for a family of four—only \$30 a week. This is less than half of the official government poverty level. It would benefit families with children in only ten states.

The Administration's proposal would supplement the wages of under-employed workers and those forced to work at extremely low wages, but without requiring the employer to raise wages to a decent level. It includes a so-called "work incentive" to encourage welfare recipients to seek employment, but no provision for the greatly expanded training and employment programs or assurance of decent wages to participants in them without which the "incentive" will be all but meaningless.

But if the Administration's welfare proposal is inadequate, the existing program is far worse. Instead we need a federal welfare program providing decent incomes and humane conditions for all who must depend on it. This means minimum payments at no less than the official poverty level, with supplemental work incentive benefits up to a level of 50 percent higher for those who obtain jobs. Families of workers whose earnings are below these standards should be eligible for income supplements, but employers of such workers should be required to pay at least the statutory federal minimum wage, through extension of Fair Labor Standards Act coverage to all workers. Mothers with children should not be forced into work or training but opportunities should be available to them on a voluntary basis. This will require a considerable expansion of day care facilities and services. Therefore, be it

Resolved: This Convention hereby recommitts the trade union movement with renewed vigor and determination to the goal of wiping out poverty in America.

Achievement of this goal will require the full use of a host of programs, old and new, which in combination will respond to the many different causes of poverty. In particular, we will seek the radical improvement of training and employment, minimum wage, social insurance, welfare and supportive programs, all of which can and should contribute to the elimination of poverty.

The public welfare system must be completely revised to provide a federal welfare program, with adequate payments based on the sole criterion of need, and with federal financing and administration of welfare costs.

We are convinced that America has the knowledge and resources to wipe out poverty in our time.

The CHAIRMAN. Are there any questions of Mr. Biemiller?

Mr. Burke?

Mr. BURKE. On page 8 of your testimony, at the top of page 8 under the Retirement Test, if the Gilbert bill is not adopted and an increase of 15 percent is granted in social security, would your organization oppose raising that exemption from the proposed \$1,800 up to \$3,000?

Mr. BIEMILLER. I refer that to Mr. Seidman, our social security director.

Mr. SEIDMAN. Yes, I think that we would oppose raising it from \$1,800 to \$3,000. We have examined the incidence of the effect of the retirement test and what we find is that by eliminating the retirement test you tend to benefit people with higher earnings or who are obtaining higher benefits. The extra cost therefore tends to be used for getting higher incomes to people who already have higher incomes than most social security beneficiaries. So that in a choice between that kind of a step and raising the levels of benefits for other social security beneficiaries at lower incomes, we would choose the latter.

Mr. BURKE. You would oppose raising it to \$3,000. Would you oppose raising it to \$2,500?

Mr. SEIDMAN. I think that we would consider this, particularly in the light of what the Congress was doing with respect to the overall increase in social security benefits.

Mr. BURKE. I am saying if a 15 percent increase takes place.

Mr. SEIDMAN. With a 15 percent increase in benefits, I don't think that we would oppose an increase to \$2,500 but I think that we would feel it would be better to increase the benefits more than 15 percent and use that same money for that purpose rather than for increasing the level of the retirement test.

Mr. BURKE. I think both of them are tied in together. I know there are those that want to get the people out of the labor market when they reach 65 years of age, but I can't see the point in getting them out if the poor people aren't receiving enough from social security to survive. I know in my district I have received thousands, not hundreds, thousands and thousands of letters from social security recipients who can no longer carry their homes, pay the mortgages on their homes, and everything else that they are required to do under the present inflated economy. They object strenuously to this ceiling of \$1,680 because they find out that the penalties that are put upon them are so severe that they can no longer continue to live in the home that they have carried for 25 years while they were working with the increased real estate taxes and other burdens that are placed on the average homeowner.

I would like to have a statement from the AFL-CIO in relation to this, your statement here, "For that reason we do not oppose" raising it to \$1,800. I would like to know just what you favor. I think this is very important today.

I can understand why labor organizations would like to get some people out of the labor market, but I can't in my heart understand why the AFL-CIO would want people to get out of the labor market and be subjected to less than poverty income. This has never been a philosophy or principle of the AFL-CIO, to my knowledge, and I think that what you are doing here is you are depressing this possibility of some of our elderly people to survive by keeping this figure down as low as \$1,800. You don't oppose it, but I would like to have an affirmative answer on what you favor.

I don't like to get into a disagreement with the AFL-CIO. I recognize they are a very powerful organization. But I do believe that there is a terrible injustice being done to these elderly people on keeping their earnings down and preventing them from living in a home and

paying their bills by having this ceiling on the wage earner when there is no ceiling on unearned income, and I think we either ought to be able to raise the benefits by 50 percent and then set a ceiling at a reasonable level or if the social security benefits are only raised 15 percent, then I think that we should not hold these elderly people below the poverty level.

So, therefore, I would like to have from the AFL-CIO a statement on just what kind of a ceiling they would favor if there is a 15-percent increase granted.

Mr. BIEMILLER. We would be very happy, Congressman, to submit a statement analyzing this entire problem and answering your question. (See p. 1804.)

Mr. BURKE. I would like to praise the AFL-CIO for having the Gilbert bill filed. I want to point out that the late Senator Robert F. Kennedy filed a bill similar to the bill that I filed calling for a 50-percent increase and the late John Fogarty, Congressman from Rhode Island, had filed this 50-percent bill and had recommended a change in the formula for collecting taxes, and I think it is about time that the Congress realized that these small pittances of increases that they are granting are just continuing the agony. Fifteen percent won't do very much for the elderly in this country today when the average social security recipient is receiving around \$100 a month.

I believe we have to grab the bull by the horns and go in there and grant a 50-percent increase and change the formula of the taxes because the employer and the employee are paying quite a bit today and the Government is freighting down social security with all kinds of things that are hiking up the cost and the Government is failing to pay back into the social security trust fund an interest rate comparable with the interest rate that they are paying in the open market.

There are so many things that they are doing that are siphoning off the funds of this social security trust fund and I think that if they did away with all these practices we could grant that 50-percent increase this year.

That is all, Mr. Chairman.

The CHAIRMAN. Any further questions?

Mrs. Griffiths?

Mrs. GRIFFITHS. I would like to ask you, does the AFL-CIO support the idea of a husband being able to draw on a wife's social security record?

Mr. BIEMILLER. Mr. Seidman?

Mr. SEIDMAN. We do support the idea of a dependent of—a wife?

Mrs. GRIFFITHS. Of a dependent husband. You mean the AFL-CIO is going in for a means test? Why?

Mr. SEIDMAN. You asked whether we support the idea of—

Mrs. GRIFFITHS. A husband drawing on a wife's social security record.

Mr. SEIDMAN. In other words, the question of whether we would favor the combining of the two records?

Mrs. GRIFFITHS. No, not at all. I am going to ask you that next.

The first one is supposing a husband didn't work under social security. He was never under covered employment. Will you support the idea of his being able to draw on his wife's record?

MR. SEIDMAN. I would say that in ordinary cases we would not support this.

MRS. GRIFFITHS. Why not?

MR. SEIDMAN. Not on theoretical grounds, but because we think that in most such circumstances, unless you are talking about a dependent husband—that is something else again.

MRS. GRIFFITHS. I am not.

MR. SEIDMAN. But unless you are talking about a dependent husband, it would seem to me that this would mean higher benefits for people who ordinarily are able to obtain retirement income in other ways, especially if you are talking about a husband who has been covered under some other system.

MRS. GRIFFITHS. Why don't you then demand that the wife be a dependent wife before she can draw on the husband's record? Why are you permitting wealthy women to draw on social security but refusing to permit a husband, not supporting the idea of a husband's drawing on social security?

MR. SEIDMAN. We don't think the question of whether people draw on social security should be determined on a needs basis. We don't think that social security should be on that basis.

MRS. GRIFFITHS. Except for men. You are favoring a needs basis where men are concerned, is that right?

MR. SEIDMAN. No, we don't think it should be on a needs basis. This would be introducing a new feature into social security and it would be a question of choosing this rather than some other thing that might be done as a new feature in social security or an improvement in benefits under social security.

MRS. GRIFFITHS. Well, the real truth, I think, if you would bother to check it, is that in general the men who would draw under social security are now aged men who are not really in good circumstances at all. Some of them are drawing veterans benefits. The wives never did earn very much money.

I would like to bring this forcefully to your attention: that a lot of them that worked for the AFL-CIO were working under contracts that were paying them less than men with a different type of category, a different name, working right beside them, so that in many instances you would be doing a really great good if you permitted the husband to draw under social security, and don't bother to ask was he supported by his wife. That is nonsense. It is a fringe benefit. You really must be for all fringe benefits being the same, aren't you?

MR. SEIDMAN. Yes, we are for fringe benefits, but I don't know that we would characterize this particular proposal as that.

MRS. GRIFFITHS. Why don't you? Do you consider social security welfare?

MR. SEIDMAN. No, we do not consider social security welfare.

MRS. GRIFFITHS. Do you consider that the worker paid for the benefit?

MR. SEIDMAN. We do consider that the worker pays for part of the benefits.

MRS. GRIFFITHS. Why isn't this a fringe benefit?

MR. SEIDMAN. If I may say so, I think there is a problem that you in particular have raised through the years which I think ought to be considered very seriously.

Mrs. GRIFFITHS. Then why don't you mention it, that is, combining the wages?

Mr. SEIDMAN. Pardon?

Mrs. GRIFFITHS. Combining the records of a husband and wife? Why didn't you mention it in here?

Mr. SEIDMAN. I think this is one of the things that ought to be looked into.

Mrs. GRIFFITHS. Why didn't you support it in here?

Mr. SEIDMAN. I don't know that we are prepared to support it, but we would like to see further exploration of this problem to see whether there is a practical solution to it and we would certainly be interested in cooperating in any efforts in that direction.

Mrs. GRIFFITHS. Well, I am delighted you said that, because I have never gotten any of you to say even that before. Nobody speaking for the AFL-CIO has ever been willing to admit that there was even a problem.

Let me show you some of the problems. As this base goes up to \$9,000 or \$10,000, the people that are really going to be discriminated against are the people that are below the actual base where it takes two people to make the money to support a family. Now, I was in a hearing a few weeks ago where a builder pointed out that today in suburbia it is going to take 55 percent of the husband's wage to pay for a house, 55 percent, and he said that is when mama goes to work, and it is. But if you do not permit those people to draw on that combined wage record in some way, whether you permit the husband to draw half of his wife's or a quarter of his wife's and the wife a quarter of her husband's record, you are really discriminating against them. They are paying the bill for everybody else to draw, to the tune of about \$2 billion a year.

Now, I would like to point out to you another place where it is really unfair and women are beginning to see this. I receive letters from women who are left widows sometime between the age of 40 and 50. They go to work. They really aren't making any money. The mean average wage of a woman is \$4,000 and these women who are in a very difficult situation are probably making less than \$4,000. On that meager wage throughout their working life, they pay a tax. For what? They are never going to draw on theirs. They are going to draw on their husband's social security record.

If you could just say to those widows, "Look, when you finish paying this tax, we are going to give you some additional amount, plus your husband's," you might make it make sense to them, but it doesn't make sense today, not one bit. So I am glad to hear that at least you are considering this, and I wish you would put it in writing some place.

Do you think you could do that?

Mr. SEIDMAN. We would be glad to put in writing that we would be prepared to consider proposals which would deal with the problems that you have raised. Yes, we certainly would. (See p. 1804.)

Mrs. GRIFFITHS. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Any further questions?

Mr. Gilbert?

Mr. GILBERT. I wish to congratulate Mr. Biemiller and his staff for

his fine presentation this morning and particularly for the support of the Gilbert bill.

May I ask this question: About how many countries have a social security system?

MR. SEIDMAN. Most countries in the world now have some kind of social security system, including many of the so-called developing countries.

MR. GILBERT. And about how many of these countries that have the social security system rely upon general revenues as a method of payment to the recipient of social security?

MR. SEIDMAN. To the best of my knowledge, Congressman, I don't think that there is any country which does not have some substantial amount of general revenue in its social security system.

MR. GILBERT. As I understand it, our system is about the only one in the world where the Government doesn't make a contribution to the social security system.

MR. SEIDMAN. I believe you are absolutely correct, Congressman.

MR. GILBERT. Thank you very much.

THE CHAIRMAN. Any further questions?

MRS. GRIFFITHS. Mr. Chairman, I would like to ask one other thing.

THE CHAIRMAN. Mrs. Griffiths.

MRS. GRIFFITHS. Do you gentlemen oppose requiring a widower to take work or training where he has children at home?

MR. SEIDMAN. If that widower is required to be at home to take care of his children and there is no other way of those children being taken care of adequately, then I would say that his treatment ought to be no different than that of a widow or anybody else, any woman in a similar situation.

MRS. GRIFFITHS. Do you think it is all right for him to quit work if he has a fairly high paying job? Do you think he has a choice between leaving a good job and staying home and taking care of the children?

MR. SEIDMAN. If he has a decent paying job, I don't see that he would have any incentive under those circumstances to quit work.

MRS. GRIFFITHS. Well, do you think he should be given that choice?

MR. SEIDMAN. I would say that I don't think it would be practical for him to be given that choice because I think that he personally would certainly prefer to work to get a higher income for his family and not to be at home with his children.

MRS. GRIFFITHS. Are you then for a means test on who has a choice and who doesn't?

MR. SEIDMAN. No, this is not a question of a means test. In the welfare program, I think that we are talking about payments based on need. There is no question about that. But I don't see that a means test applies in this situation. I think that by and large—maybe I am just speaking based on my own experience—most husbands under such circumstances would want to remain in good paying jobs and work out some other way of taking care of their children than to quit their jobs and at lower incomes be at home with their children. There may be some rare exceptions.

MRS. GRIFFITHS. That is just your guess as to what they might want to do and maybe I would guess they might want to do it that way, too, but if you think that a woman should have a choice as to whether she goes to work or not and she is left with the children, why not give men a choice? What difference does it really make?

Mr. SEIDMAN. I think in most such instances the chances of a man getting a decent paying job which will take care of the needs of his children are much better and, therefore, I would think that it would make some sense to give him every possible incentive to go to work under those circumstances.

Men, by and large, are not as well qualified as women to take care of children in our society.

Mrs. GRIFFITHS. Would it surprise you if I said that in a town where in general the women work and the men stay at home they have the least juvenile delinquency in America? So maybe we have had the wrong people taking care of the children all these years.

Mr. SEIDMAN. I think that perhaps in that town there are a lot of other social problems.

Mrs. GRIFFITHS. Thank you, Mr. Chairman.

The CHAIRMAN. Any further questions?

Mr. CORMAN. Mr. Chairman?

The CHAIRMAN. Mr. Corman.

Mr. CORMAN. Mr. Biemiller, I, too, am very impressed with your statement. I appreciate the specifics of your recommendations. I think we both would acknowledge that we are probably a long way from total Federal funding of public assistance. At present, I suppose most programs average out that the Federal Government pays about half and the State Government about a fourth and local government about a fourth.

Now, if we are going to shift from that pattern, will you agree that our first priority ought to be to remove from local government all of the expense of public assistance?

Mr. BIEMILLER. Mr. Seidman?

Mr. SEIDMAN. Yes, I think we would agree with that, Congressman. Our feeling would be, as you have stated, that we would be in favor of federalization of the program, but if the States are going to continue to play a role, then we think that they ought to play a role on a statewide basis and that statewide administration and financing is preferable to part State and part local for the State share.

Mr. CORMAN. On the matter of mandatory work for welfare recipients, it seems to me there is great danger in their being a lack of uniformity as to that requirement. If we write it in the Federal law it may be used in a great number of places to remove the needy from public assistance when the jobs are not adequate, when the recipients are not physically or mentally capable of holding the jobs they are sent to, or when child care is not provided.

Do you think that is a realistic concern?

Mr. SEIDMAN. Yes, Congressman, we think it is a very realistic concern. We are particularly concerned about the fact that this proposal is now being combined with a proposal to decentralize the manpower program. Since that aspect of the public welfare proposal of the administration will depend very largely on the manpower program, we are fearful that there will be a great lack of uniformity and equity in the treatment of public assistance recipients from one area to another.

Mr. CORMAN. It seems to me, in view of the lack of uniformity now in the level of subsistence between the lowest paying States and the highest, that there certainly is reason to believe that there will be lack

of uniformity in administration. I would just like to underscore your suggestion that when we have gone far enough down the line and find jobs going unfilled and places in child care centers going unfilled, that is then the time to consider the advisability of mandatory work for recipients.

Thank you very much.

The CHAIRMAN. Any further comment or questions?

Mr. CONABLE?

Mr. CONABLE. Gentlemen, we have had a social security system that has been essentially wage-related, and I understand you to say that you don't favor making it welfare-related as such although you favor substantially increasing the minimums, putting in money from outside the system from the general Treasury as well, I suppose, to permit the financing of additional benefits beyond what would normally be payable out of payroll taxes. You have a lot of people that you represent who have been for years paying into the social security system. They have been doing it on the basis of its not being just another tax, but being a wage related retirement insurance system.

Do you see any risk, if we were substantially to increase the minimums, to finance these costs out of the general treasury and out of a very substantially increased wage base, that your constituents and mine might feel that all these years they have been paying in effect not a contribution to their retirement future but just another tax and they might feel that they had been sold down the river by politicians, and robbed of their investment?

Mr. BIEMILLER. Mr. Seidman?

Mr. SEIDMAN. Congressman, I don't see that there is that risk if, at the same time we are bringing about substantial improvements in the level of social security benefits to the general beneficiary. I am not talking just about the person who is receiving minimum benefits. What we are advocating is not the use of general revenue to pay for a higher minimum benefit. We are arguing that general revenue is needed to substantially improve the social security system in various ways across the board, one of those ways being to bring about a more realistic level for the minimum benefit. But that is only one of the improvements that we are suggesting and we think that if workers recognize that through their contributions they are going to be able to get social security payments in their retirement or when they are disabled at a level which is sufficient to maintain a decent standard of living, then I think that there will be no such resentment.

Mr. CONABLE. I am interested in the psychology of this because I think we do have to concern ourselves with psychology. At the time of the 1967 Act I had a veritable outpouring from my district of letters from people who said they didn't want to see social security turned into a welfare system, and yet I am just wondering if it will be as acceptable a part of the American social scene if because we are tapping general Treasury funds in substantial degree it becomes suddenly obvious that the whole thing is subject to political control and not subject to the usual rules of actuarial soundness? I think this is something that we must concern ourselves about because the payroll taxes are a very substantial burden on employees, both through their own and through the employer's contributions, and if they come to the opinion that this is just another tax on them, I think they may have

a very strong and not a bit subtle change in their attitude toward their own contributions to the system.

Mr. SEIDMAN. Congressman, as we have pointed out in our testimony, and some of your colleagues have indicated, the idea of a partial general revenue contribution to social security is not something which is either new or unprecedented. We have a certain amount in our system. The fathers of our system felt that this was what should be done about now or a little earlier with the system that we have.

It is being done all over the world.

But let me say just one other thing. We in the AFL-CIO always have been concerned with maintaining the actuarial soundness of the social security trust fund and the social security system as a whole. It is our conviction that the bill that we are supporting, the Gilbert bill, is actuarially sound. We know that this is true because the Chief Actuary of the social security system has indicated and has found that it is actuarially sound.

We are not making proposals which would in any way detract from the actuarial soundness of the social security system, although we are advocating a new feature within that context.

Mr. CONABLE. It is actuarially sound only if the contribution from the general Treasury is an uncontrollable contribution, is it not?

Mr. SEIDMAN. No, it is no more open ended and no more uncontrollable than the present contributions. We have, as you know, in the social security law a schedule for future increased contributions by employers and employees to the social security system. This proposal calls for a general revenue contribution on a schedule, a schedule which the actuary has been able to determine in advance.

Mr. CONABLE. But the general Treasury contribution would have to be uncontrollable?

Mr. SEIDMAN. May I just go on to say that it is within the discretion of future Congresses, just as it has happened in the past, to change the level of contributions required of employers and employees just as it will be in the discretion of future Congresses to determine what level of contribution would come from general revenue for the social security system. Both are a question of the discretion of the Congress. They are now and they will continue to be in the future, but both are questions of discretion of the Congress to the same degree.

Mr. CONABLE. But you make it sound as though our trust funds are right in the category with the general Treasury. There is quite a difference there, isn't there?

You say they are subject to the control of Congress because we can vary the amount of the payroll tax and, therefore, it is no different from money coming from the general Treasury. I can't agree with you on that.

Mr. SEIDMAN. Yes, I do think that it is the same. I think that both are subject to change in the future.

Mr. CONABLE. Why do we have trust funds then? They are supposed to be inviolable.

Mr. SEIDMAN. Yes, but the money that goes into the trust fund doesn't necessarily have to come from one source or another. That isn't what constitutes the characteristic of the trust fund. The trust fund is a fund which is built up from contributions from whatever source on an actuarial basis in order to pay the benefits which the Congress provides for.

Mr. CONABLE. I would just like to suggest to you, sir, that you are injecting an element of instability into our social security system that is not there now if you are advocating one-third contributions from the general Treasury as the basis for substantially increased benefits. We all want to do what we can to increase benefits but, at the same time, we want to keep faith with the American workingman and assure him that his investment in his future is not going to be subject to the type of political manipulation which is an inevitable part of contributions from the general Treasury. These contributions tend to reflect the political programs, the social programs, of the administration in power to a substantial degree, and one thing about the Social Security Administration is that it has stood as a rock, an investment in the American workingman's future, largely because it was not subject to the vicissitudes of politics or changes of administration attitude.

That is all, Mr. Chairman.

The CHAIRMAN. Any further questions?

If not, we thank you, gentlemen.

Mr. BIEMILLER. Thank you very much, Mr. Chairman.

(The information requested by Representatives Burke and Griffiths follows:)

AMERICAN FEDERATION OF LABOR AND
CONGRESS OF INDUSTRIAL ORGANIZATIONS,
Washington, D.C., November 19, 1969.

HON. WILBUR MILLS, *Chairman,*
Ways and Means Committee,
U.S. House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This letter is in response to requests made by two members of the House Ways and Means Committee, Congresswoman Griffiths and Congressman Burke, at the time I presented AFL-CIO testimony on pending Social Security legislation. Congresswoman Griffiths requested the AFL-CIO's position on combining the social security earnings records of a man and wife for the purpose of determining benefits and Congressman Burke requested our position on raising the earnings exemption for retirement test to \$3,000. Since that time, Congressman Vanik has sent me a letter requesting our position on the Administration's proposal to defer the already legislated increase in the social security tax. For that reason, I am also including our views on this matter.

THE WORKING WIFE AND SOCIAL SECURITY BENEFITS

As we understand it, the issue is a married woman who is potentially eligible for benefits on either her husband's earnings or her own earnings. Many married women feel that they do not receive an adequate return on their contributions, because, even if they had not worked and made contributions to the program, they would have received a wife's benefit based on their husband's earnings. This problem has become all the more important because of the great increase in the number of working women.

The AFL-CIO would consider any appropriate proposal to give greater recognition to working wives which would not unduly compromise the social purposes of the program and which would not create equally anomalous situations by its adoption. In addition, since the number of desirable improvements in social security will always be greater than the number that may be successfully enacted into law, we would have to weigh any such proposal against other possible improvements.

RETIREMENT TEST

The AFL-CIO opposes abolishing the retirement test because it would add substantially to the cost of the program without meeting major social needs. Its abolition would cost the system about \$2.5 billion a year now and more in future years and would require an increase in the social security contribution rate of 0.63 percent of taxable payroll. Only 8 percent, about 1.8 million beneficiaries

age 65 and older, have any benefits withheld because of the retirement test. The primary gainers from its elimination would be the 800,000 persons who are working full time and not drawing any social security benefits.

Basically the same arguments apply to raising the exempt amount to \$3000 since the cost of this liberalization would be .47 of payroll. In addition, such a liberalization would be a major step toward eventual elimination of the retirement test and probably would make this result inevitable. Other more necessary improvements could be secured for this cost. For example, the cost of this liberalization could entirely or partially:

(1) Provide close to a 5.5 percent across-the-board increase in benefits to all beneficiaries. (.47 of covered payroll) ; or

(2) Provide a widow's benefit at age 65 equal to 100 percent of deceased spouse's benefit (.25) ; increase the lump sum death benefit from \$255 to \$500 (.09) ; permit an age 62 benefit computation for men in the same manner as for women (.10) ; reduce the waiting period for disability benefits from 6 to 3 months and without regard to subsequent duration of disability (.15) ; and include an occupational definition of disability (.10). (Total for all items—0.69 percent of covered payroll).

Each of the aforementioned changes would benefit millions of social security beneficiaries most of whom are unable to work and have little or no outside earnings. We feel it would be better to make some of the aforementioned improvements than to help a small minority of the aged who earn substantial income after retirement—many of them well-to-do.

Since earnings level rise, we deem it appropriate to adjust the retirement test from time to time to take this into account. The liberalization proposed by the Administration basically does that, and for this reason, we do not oppose it. We do feel that this is the maximum liberalization that should take place at this time and our position is independent of the magnitude of the social security increase that may be passed by Congress. I am attaching for your information, a brief policy statement setting forth the AFL-CIO position on this matter.

DEFERRING INCREASES IN SOCIAL SECURITY TAX

A recent actuarial evaluation shows the surplus in the Social Security Trust Fund to be considerably in excess of the amount needed to finance the Administration's recommended benefit increases. In fact, the Administration proposes to cut back the presently scheduled contribution rates for a number of years and, in effect, by 1973 refund \$22.4 billion now scheduled to go into the cash-benefits trust fund, and an estimated additional \$35 billion by 1987. Social security beneficiaries are in dire need. The Administration proposes a reduction in the scheduled revenue rather than applying presently scheduled revenue to needed social security improvements. Their proposed increase would not even maintain the economic status of beneficiaries in the face of rising prices. The Administration's proposal shows a witting or unwitting lack of appreciation of the plight of our elderly population.

I hope these observations will be of value to you and the Committee. If we can be of further assistance on these proposals or any other matter, please feel free to call on us.

Sincerely yours,

ANDREW J. BIEMILLER, *Director,*
Department of Legislation.

AFL-CIO POSITION ON RETIREMENT TEST

The retirement test is one of the most controversial and least understood provisions of the Social Security Act. This test provides that Social Security benefits are payable in full if a person's earnings remain below \$1,680. If earnings exceed that amount, the Social Security benefit is reduced dollar for dollar for earnings in excess of \$2,880. A full benefit is permitted for any month in which earnings do not exceed \$140 regardless of annual earnings. Persons over 72 are not covered by the retirement test.

WHY A RETIREMENT TEST

The AFL-CIO opposes abolishing the retirement test for what we consider very valid reasons. The Social Security program is an insurance program that insures against the loss of income from work and that pays benefits when that loss

occurs. In other words, the purpose is to provide insurance against the loss of earnings due to retirement, disability or death of the worker. Like other forms of insurance, the program insures against specified risks and it does not pay benefits unless the risk against which it insures actually occurs.

It is true that the retirement test applies only to earned income. By paying benefits regardless of other financial resources, Social Security serves as a base on which other forms of protection such as investments, savings, insurance, etc. can be built. Withholding benefits because of resources other than nonwork income would reduce incentive for savings and would make it impossible for most people to make provision for a more financially secure old age than would be possible by Social Security benefits alone. It would also jeopardize the eligibility of private pension recipients to receive Social Security benefits. It might also increase the danger of the introduction of a means test for Social Security recipients.

The AFL-CIO has always supported changes in the Social Security Law that were aimed at meeting major social purposes rather than the convenience of a minority. Repeal of the retirement test would increase the cost of the Social Security program by \$2.5 billion a year now and more in future years. This cost would be sufficient to finance more than a 7% across-the-board increase in Social Security cash benefits. But only 1.8 million—about 8% of the 17.9 million people age 65 and older have any benefits withheld under the retirement test. Its elimination would benefit primarily those 800,000 persons who are working full time and not drawing any Social Security benefits.

The large majority of aged persons are unable to work because of poor health or lack of employment opportunities. Obviously, this is a group for which full time work cannot be expected to be a satisfactory means of supplementing Social Security benefits. More adequate cash and medical care benefits are what is needed.

The AFL-CIO realizes that the retirement test earnings exemption must be adjusted from time to time in accordance with increases in wages and prices and that there may be need for some liberalization. But priority must be given to a substantial increase in benefits which would help all beneficiaries including the large majority who do not work after retirement and would not be helped by elimination or undue liberalization of the retirement test.

The CHAIRMAN. Dr. Watson?

Dr. Watson, we appreciate your coming to the committee. If you will identify yourself for our record by giving us your name, address, and capacity in which you appear, we will be glad to recognize you.

STATEMENT OF DR. C. GORDON WATSON, ASSOCIATE EXECUTIVE DIRECTOR, AMERICAN DENTAL ASSOCIATION; ACCOMPANIED BY BERNARD J. CONWAY, LEGAL OFFICER

Dr. WATSON. Thank you, Mr. Chairman, and members of the committee. My name is Dr. C. Gordon Watson of Chicago, Ill. I am associate executive director of the American Dental Association. With me, on my left is Mr. Bernard J. Conway, chief legal officer of the association.

The CHAIRMAN. We again thank you for coming to the committee and we are glad to recognize you, sir.

Dr. WATSON. When testifying on dental health care before this and other congressional committees, the American Dental Association has consistently attempted to make plain some basic premises: (1) there is a deplorable prevalence of dental disease in this country; (2) means are available to prevent much of this disease; (3) government at all levels can and should make a larger contribution toward this end; and (4) government and particularly the Federal Government has failed up to now to support the kind of dental programs that will assure better oral health for our citizens.

This failure has stemmed in part from an historic indifference to and misunderstanding of the nature of the problem and in part from an administrative structure that never has been coherently or cohesively organized. As a result, many Federal programs have reversed the priorities that a sound, practical program should have. The Department of Health, Education, and Welfare is spending some \$200 million a year for dental care. These funds could and should be more wisely invested.

Title XIX has been the recent focus of concern over the way in which the Federal Government helps to support delivery of health care to the needy and medically needy. The association supported the enactment of title XIX. We considered it to be the decent impulse of a generous Nation to begin doing something it probably should have been doing some years before. The association still believes that the concept is essentially sound, though title XIX may not necessarily be the ultimate mechanism of choice or the total answer. Whatever mechanism is selected, the dental aspect of it will be effective only if basic improvements are made in the Government's traditional approach.

As members of this committee well know, the incidence of dental disease in the Nation is enormous. At any given point in time, the existing backlog of untreated disease is mountainous. Any attempt to bring it under control solely by means of reparative and rehabilitative services is, in practical terms, doomed from the start. Instead, we must concentrate our limited resources on preventive services, maintaining dental health rather than restoring it after disease has made its inroads.

As a matter of logic, this means paying special attention to the dental needs of children for if we can manage to bring a generation of children to maturity while in possession of oral health, then we will have begun to bring dental disease under control. Children are today as much the victims of the current incidence of disease as any group. The average 15-year-old child in this Nation has already had one-third of his teeth attacked by dental disease. Among children in lower income-education groups, disease of the soft tissues of the mouth are a major problem.

When title XIX was originally being considered, we urged that the proposal be amended to require States to focus their dental activities on children. We think such an amendment should have been made then; we think it should be made now.

In the same vein, we appeared before this committee in early 1967 to urge an amendment to title V that would authorize pilot dental care projects for needy children. The purpose was two-fold; to give care and to explore alternative methods of delivering care in order to identify the most efficient and economical ones. That amendment was approved by Congress and the President but not one penny has ever been appropriated to implement it. It would be immensely useful today if Congress could have before it the results of 2 years of such experimentation. But at a time when hundreds of millions of Federal and State dollars were being spent for dental care, mostly on a haphazard and ill-planned basis, the executive branch couldn't manage to find \$5 million or so to launch this effort.

The House Appropriations Committee, in its report on fiscal 1970 funding of HEW, included the following paragraph on this subject:

The Committee is concerned about the lack of a coordinated program for the dental health of children while so many federal dollars are being spent under Medicaid and similar programs to treat dental conditions in adults that could have been prevented. The Committee will expect that some of the funds provided in this appropriation will be used pursuant to the authorization in section 510 of Title V of the Social Security Act relating to special project grants for the dental health of children.

We agree fully with that statement and hope the HEW will allocate a realistic sum for this purpose.

The efficient use of the Federal dental health dollar, whether allocated under title XIX, title V or elsewhere, also depends heavily upon a coherent administrative structure for overseeing these expenditures. Such a structure has never existed. Dental activities are badly fragmented. The modest amount of money totally available is thus further divided and its impact further weakened. There has been no dental position within HEW's top management. There are no dental positions of consequence within the Social and Rehabilitation Service, the Health Services and Mental Health Administration, the Consumer Protection and Environmental Health Service, the Office of Education or the Social Security Administration though, in each case, there is dental money being spent and, inevitably, policy being made.

Many of the troubles that have vexed title XIX dental programs have their root causes in such administrative shortcomings. Action on them must be taken if there is any hope for improvement.

Two other matters relating to experience with title XIX deserve brief mention.

The first touches the expense of the program. Some observers have not yet fully appreciated the fact that delivering comprehensive health care to the millions of Americans eligible under such a program as title XIX is going to be expensive no matter how prudent and efficient a mechanism is devised. It is our belief that the bulk of the money being expended by medicaid dental programs represents care given to people who were not receiving it heretofore.

To the degree that dental fees contribute to expense, three facts should be kept in mind: first of all, increases in dental fees have been more moderate since 1957-59 than increases in all other items measured by the Cost Price Index against which dental fees can be most appropriately measured (hospital daily charges, physicians fees, services less rent, et cetera); secondly, dental fees constitute barely 5 percent of the total medicaid expenditures, and finally, dental fees under medicaid have been rigidly controlled by the States with the most comprehensive dental programs, being in at least one instance as low as the 20th percentile of the prevailing fees.

To say these things is not, of course, to attempt to defend in any way a dentist who has abused title XIX. Any such practitioner should be brought promptly and severely to account. The administration has said it will seek changes in the law to facilitate this. While we do not necessarily object to their doing so, it is surely true that defrauding a public program is already grounds for disqualifying a participant. We hope equal energy is devoted to considering administrative changes that will make it possible for abuse to be uncovered with dispatch and not months after payment checks have been made.

We should also like to note that attempts at broad scale reduction of dental spending for purposes such as those of title XIX must take into account the fact that barely 2 cents of today's Federal health dol-

lar is allocated to this activity, in distinction to the private sector health dollar, 9 cents of which is spent for dental care. The need and demand for care under programs like title XIX is already so large that stringest priorities are needed as long as the Government declines to allocate a more reasonable amount of money to this purpose. Further reductions would be most damaging.

Of equal importance to the expense involved is the quality of the care received. Certainly, all parties deserve to feel assurance on this vital matter. It is our belief that peer review is a necessary feature of any system directed toward providing such assurance. Peer review is part of many dental care contracts in the private sector that are administered by dental service corporations, the counterparts to Blue Shield. Labor, management and the profession work cooperatively to keep the standards of such programs high and the cost as low as possible. These programs have not encountered the kinds of difficulties that title XIX seems to have had. They incorporate procedures that permit and encourage mutual cooperation at the beginning and allow all interested parties to participate in policymaking from the very start. Such an approach could well eliminate some of the difficulties that have arisen in some States.

For example, a dispute arose in one State when its title XIX agency attempted to impose conditions beyond State licensure as a prerequisite to participation in the program. An amendment to clear up this situation and bring title XIX into conformity with title XVIII has been introduced by Congressman Broyhill of this committee (H.R. 4570). We urge its approval.

Similarly, the Association would like to recommend a perfecting amendment to title XVIII. Upon occasion, an elderly person who is otherwise in good health needs to be hospitalized in order to undergo a dental procedure. The resulting hospital costs are covered by most health policies, including those for Federal employees. They are not, however, presently allowed under part A of title XVIII. This, in our view, works an unjust hardship on the relatively few elderly persons involved. In the last session of Congress, an amendment to bring medicare into conformity with prevailing practice was introduced by Mr. King, then a member of this committee (H.R. 18940). Such an amendment would in no way enlarge dental benefits under title XVIII but would simply cover hospital costs under the circumstances outlined. We believe this change should be made, and we are pleased, Mr. Chairman, to say that Congressman Corman plans to introduce a bill to this effect.

Finally, with the committee's permission, the Association intends to submit a statement of its views on the Health Cost effectiveness amendments of 1969.

Mr. Chairman, this concludes our testimony. We are most grateful for this opportunity to present our views and Mr. Conway and I would be glad now to try and answer any questions.

The CHAIRMAN. Without objection, the additional submission will appear in the record at this point.

(The document referred to follows:)

SUPPLEMENTAL STATEMENT OF THE AMERICAN DENTAL ASSOCIATION CONCERNING
HEALTH COST EFFECTIVENESS AMENDMENTS OF 1969

By way of prologue, the Association would like to reiterate two beliefs that materially affect any attempts at improving health cost effectiveness. The first is that the small amounts of money now being made available for dental care under Social Security programs will never, under the most stringent cost effectiveness yardmarks conceivable, provide a decent level of dental care for the total number of potential beneficiaries. Until the government is willing to fund its part of the total cost more reasonably or, alternatively, to make definite priority choices, such as one in favor of children, discussions of health cost effectiveness with respect to dental care under Social Security will not be meaningful. And secondly, the federal government must recognize more clearly the connection between health manpower programs being implemented today and the level of availability of health care services in the future. If health manpower programs are starved today, then health care services are going to suffer in the years ahead.

With specific reference to the Health Cost Effectiveness Amendments of 1969, the Association would like to make the following comments:

(1) The requirements in Section 4 concerning incentive reimbursement experiments to be undertaken by the Secretary are, we believe, unduly harsh with regard to involuntary participation. The lack of definition of the term "undue hardship" should, in our view, be remedied. It is also our conviction that the necessity for prior consultation of local institutions and organizations should be more explicitly recognized and provided for in detailed steps.

(2) The Association believes that the sequential chain of review in Section 5 respecting providers suspected of abuse is faulty in that public notice of disqualification is prior to a hearing and a court review. It should be subsequent to those two steps. Section 5 is also, we believe, unreasonably permissive in granting authority to the Secretary to make inspections of fiscal and other records. The right of inspection ought to be possessed by the Secretary where he can show reasonable cause for suspicion of abuse rather than have it be an unlimited grant of authority. The Association assumes that the Secretary, in creating a national program of review, will, in the case of dental services, be required to consult with national dental societies and with the respective state dental societies and that the review teams will be required to include dentists in a just proportion.

Dr. WATSON. Thank you.

The CHAIRMAN. Are there any questions of Dr. Watson and Mr. Conway?

If not, we thank you gentlemen very much for bringing to us this very fine statement.

Dr. WATSON. Thank you, Mr. Chairman.

The CHAIRMAN. Our next witness is Mr. Walters.

Mr. LANDRUM. Mr. Chairman?

The CHAIRMAN. Mr. Landrum.

Mr. LANDRUM. I would like the record to show that Mr. Walters is not only a long-time personal friend of my family and me but one who has from the earliest days of his public activity been extremely interested in the welfare of people, having come first to that through the teaching profession and then through his many years of service here in Washington as one interested in civil service and those retired under the provisions of that law.

Mr. BROYHILL. Will the gentleman yield?

Mr. LANDRUM. Be glad to yield.

Mr. BROYHILL. I should like to associate myself with the remarks of the gentleman from Georgia. I have known Mr. Walters for a number of years as a close friend. I became acquainted with him during the 17 years I served in the Congress, and particularly during the 11 years I served on the Post Office and Civil Service Committee. I knew him to be a devoted public servant and a friend of all Federal em-

ployees. I say the gentleman has rendered outstanding service to all Federal employees and he is rendering an outstanding service now to the retired civil employees. I would like to join with my friend from Georgia in welcoming you to the committee today.

The CHAIRMAN. We appreciate having you with us, Mr. Walters.

STATEMENT OF THOMAS G. WALTERS, PRESIDENT OF THE NATIONAL ASSOCIATION OF RETIRED CIVIL EMPLOYEES; ACCOMPANIED BY MISS JUDITH PARK, ADMINISTRATIVE ASSISTANT, LEGISLATION

MR. WALTERS. Thank you, Mr. Chairman, and through you I would like to thank my own Congressman, the Honorable Phil Landrum, and my good friend, Congressman Broyhill, for those kind remarks.

I might add, as I stated here in February, that the Landrum family and the Walters family have been neighbors for many, many years and that the honorable Congressman's father was my first school teacher, and if I have amounted to anything maybe the first teacher got me started off on the right road and under the leadership of our friend in Congress.

Mr. Chairman, and members of the committee: My name is Thomas G. Walters, president of the National Association of Retired Civil Employees. I am accompanied this morning by Miss Judith Park, administrative assistant to the president on legislation. Our organization was formed February 19, 1921, and has been in continuous operation since that date. We now have over 135,000 members with more than 1,100 chapters in every State in the Union, Puerto Rico, Canal Zone, and the Philippines. Our membership is made up exclusively of retirees from the Federal Government and their survivors, and I appear this morning on behalf of our membership plus all other civil service annuitants and their dependents in the interest of legislation which relates to the treatment of these people.

We appreciate the privilege, honor, and opportunity of appearing for the second time before this committee in the interest of the members of the National Association of Retired Civil Employees. We extend our thanks to you, Mr. Chairman, and to each member of the committee for the time you are devoting to rewrite and liberalize the tax laws and the medicare program which affects directly or indirectly every American citizen.

SOCIAL SECURITY AND MEDICARE

The National Association of Retired Civil Employees strongly supports an increase in social security benefits, as well as a general increase in all annuities under the civil service retirement system, realizing that increases under the Federal retirement system comes under the legislative scope of the House and Senate Committees on Post Office and Civil Service. We believe, and our organization has passed strong resolutions, that medicare should be amended to include prescription drugs for out-of-hospital patients. We receive hundreds and perhaps thousands of letters from annuitants and survivors, especially those receiving less than \$3,000 a year telling us they just don't have enough money to pay for prescription drugs. About 15 bills to provide for prescription drugs have been introduced in the House, some

by members of this very committee as H.R. 981 by Congressman Boggs.

We believe that retired Federal employees and their survivors at age 65 should be eligible for full medicare coverage, both parts A and B. They are now eligible for only part B which is doctor's benefits. Only those who retired prior to July 1, 1960, and reached age 65 before January 1, 1968 are eligible for part A, hospital coverage.

Some of the health benefits plans under the Federal employees health benefits program, which became effective July 1, 1960, provide for coverage of items such as dental and eye care. We feel that the time has come for medicare to be amended to pay at least a portion of the expense of dental care, dentures, eye care, eyeglasses, and hearing aids. Our members would be willing to increase their payments to cover costs of additional benefits. Thousands of our members, especially those on low annuities, and the same is true for social security, just do not have the money to give attention to the items which we have enumerated in this program and which are so often necessary for the elderly.

Our association is also working with the House and Senate Committees on Post Office and Civil Service in an effort to have a technicality removed from the Retired Federal Employees Health Benefits Act, so that medicare can be listed as a qualified plan for the purposes of the Government contribution. Federal employees who retired prior to July 1, 1960, are eligible to be covered by the Retired Federal Employees Health Benefits Act, under which the Government pays \$3.50 each month toward the cost of premiums in either a qualified private health plan of the retiree's own choice or in a special uniform plan set up by the U.S. Civil Service Commission. However, should the retiree prefer medicare's part B to private insurance or the uniform plan, the Government cannot make any contribution toward the cost of the medicare enrollment. Only a technicality in the law, which was enacted before medicare, prevents them from doing this, and we are attempting to have this situation remedied. I feel reasonable sure, Mr. Chairman and members of the committee, that the U.S. Civil Service Commission would support this type of amendment.

TAX RELIEF FOR THE ELDERLY

As president of NARCE we deeply appreciate the work of this committee on the tax reform bill, but we continue to sincerely believe that our members would appreciate more an across-the-board tax exemption which could be easily understood. Our organization has long recommended that the first \$5,000 of annuity for a family, and \$3,600 for a single person be excluded from the gross income under Federal income tax.

Until 1947 those of us who were over 65 and retired were eligible to deduct drug and medical expenses and we strongly recommend that this provision be reinstated in the tax reform legislation.

We strongly urge and believe that the time has now arrived when the Federal annuitants and survivors and those under social security should have a minimum benefit of not less than \$100 a month for a single person or \$200 a month for a family. I believe the public would strongly support this type of legislation. There are many bills introduced in the House and in the Senate covering most of the items I

have mentioned in this statement and this demonstrates the interest of Members of Congress in the older people of this country.

In closing, Mr. Chairman, and members of the committee, we again desire to express our thanks and appreciation for this opportunity to present some of the views of the members which I have the honor of representing.

Miss Park or I will attempt to answer any questions that might be in the minds of the committee.

Thank you.

Mr. LANDRUM (presiding). Thank you, Mr. Walters.

I believe that you sought permission to have your summary appear in the record.

Mr. WALTERS. Yes, I would like to ask permission to have the summary made a part of the record.

Mr. LANDRUM. Without objection, the summary will be printed in the record.

(The document referred to follows:)

SUMMARY STATEMENT OF THOMAS G. WALTERS, PRESIDENT, NATIONAL ASSOCIATION OF RETIRED CIVIL EMPLOYEES

The National Association of Retired Civil Employees (NARCE) is a 48-year-old, non-profit organization with a membership of more than 135,000. There are some 1100 chapters in the fifty States, Puerto Rico, Canal Zone, and the Philippines. All NARCE members are former Federal employees and their survivors.

We strongly recommend that this committee seriously consider all of the items in this summary, with a full explanation in the body of the attached Statement:

I. AMEND SOCIAL SECURITY AND MEDICARE

- A. Support Social Security benefit increase.
- B. Include Prescription Drugs under Part B (Medical) of Medicare.
- C. Extend full Medicare coverage (Parts A and B) to all Federal retirees.
- D. Include dental care, dentures, optical care, eyeglasses, and hearing aids under Part B of Medicare.
- E. Approve Medicare as qualified plan under Retired Federal Employees Health Benefits Program.

II. PROVIDE TAX RELIEF FOR ELDERLY

- A. Exclude portion of Civil Service annuity from Income Tax
 - 1. Allow \$5,000 exemption for family.
 - 2. Allow \$3,600 exemption for single person.
- B. Reinstate provision to deduct medical and drug expenses from Income Tax after age 65.

III. ESTABLISH MINIMUM INCOME FOR ALL RETIREES

- A. Allow \$100 per month for single Social Security and Civil Service annuitants.
- B. Allow \$200 per month for family under Social Security and Civil Service retirement.

Mr. LANDRUM. Are there questions of Mr. Walters?

Mr. BROYHILL. Mr. Chairman?

Mr. LANDRUM. Mr. Broyhill.

Mr. BROYHILL. Mr. Walters, I commend you for your statement to the committee this morning as well as commend you for the entire legislative program for this year as submitted by the National Association of Retired Civil Employees. I am in wholehearted accord with your proposal that something be done to correct the inequity in medicare insofar as civil service employees are concerned.

I might point out to you that the gentleman from Wisconsin, Mr. Byrnes, did propose in his alternative to medicare in 1965 that we include Federal employees. I was somewhat concerned about it in that it might have an effect on the separate health insurance program that we now have for Federal employees. It would require a double contribution into the medicare trust fund for which the Federal employee at the age of 65 would not obtain the full benefit.

You mentioned the \$3.50 that is contributed for the employee who retired prior to July 1, 1960. Of course he has a less liberal proposal, if you will recall. Yet by having this plan, although he has been granted the benefits of medicare, he has a duplicated benefit for which the Government is paying \$3.50 and he is paying somewhat more. Even with the employee who retired since July 1, 1960, chances are 50-50 that he has medicare through social security coverage from moonlighting or other employment. But concerning this separate civil service health insurance plan, to which he is entitled as an employee of the Federal Government, the Federal Government as the employer should be paying.

That also provides duplicating benefits for part A and part B, and we have tried to do something to unravel it. We tried on two occasions here, and frankly, I found sympathy within the committee to want to do something. The problem involves a question of jurisdiction with the Post Office and Civil Service Committee, and I introduced legislation that was referred to that committee that would provide for the Federal Government picking up the part B portion of a Federal employee if he has medicare. I am talking about the employee who retires after July 1, 1960. But that has not been considered yet because it is complicated, just as complicated for them as it is for us. I am hoping that you and I might be able to get together on suggestions you may have to make that this committee could consider when we go into executive session on this bill.

The Federal Government as the employer is putting out money under contract with that employee for his health insurance after the age of 65 and the same Federal Government is providing another type of program whereby this employee, if he does take advantage of it, has duplicating benefits. It isn't fair for the Federal Government to be relieved of the cost of those duplicating benefits and it isn't fair to the employee to have to pay for both benefits. So I am hoping that you can come up with some suggestion. I am not speaking for the committee, but it is my understanding that there is sympathy in the committee to do something in this area.

Mr. WALTERS. I sure appreciate those comments, and we have drafted an amendment that the attorneys tell us will make it possible for these people who retired prior to July 1, 1960 to be qualified to take their \$3.50 and pay it towards their medicare rather than some other qualified plan, and I would be happy to follow your suggestion and get with you some time immediately to look toward this, but if this committee could in their report to the House, even though you couldn't perhaps technically have jurisdiction to do it, if you could just make a statement of some kind that you see the need for this attention and make some kind of a recommendation, it would certainly strengthen our hand over at the other place because you are well aware that we have discussed this with members of the other committee, and they

are not opposed to these things. It is just a matter of attempting to find a way and a time in which to bring it about, and perhaps in the wisdom of this committee you could just make a recommendation that you feel the need for attention to the people who retired prior to 1960.

I am sure all of you agree it is impossible for them to get as good a health benefit coverage as it is for the people who are in the service and those of us who retired since 1960, and all of these people who retired prior to 1960 are getting older and the number is getting smaller and there will never be any more new blood, so to speak, added to that group, and it just seems to me that not willingly but they have been denied the benefits of Medicare from this \$3.50 point of view so I would be delighted to do whatever we can to cooperate with you.

Thank you.

Mr. BROYHILL. One area you touched upon that is definitely within the jurisdiction of this committee, concerns the exemption of taxes on annuities. There is a bill pending before the committee which your organization has recommended that would update the exemption of taxes on other annuities, particularly civil service annuities, in keeping with the tax exemption of social security.

Mr. WALTERS. That is right.

Mr. BROYHILL. Now, the Congress has recognized that and has acted when the maximum social security, I think was \$1,560. Now that it has gone up, we have not followed through by increasing the formula that would give a comparable exemption to civil service annuities. I am hoping we can do that when we consider the social security amendments this time.

Mr. WALTERS. You may be too modest to mention it, but you have a bill on that which we are very proud of and so has the acting chairman, Congressman Landrum, and perhaps others, but those are some of the many things that call for our attention and our people just honestly feel, and I think rightfully so, that somewhere along the line they missed the boat when social security and railroad retirement get theirs without any tax as far as, as we call it, out in the public.

Mr. BROYHILL. That is all I have.

Mr. LANDRUM. Mr. Byrnes?

Mr. BYRNES. No questions.

Mr. LANDRUM. Thank you, Mr. Walters.

Thank you especially for the recognition of the efforts of certain members of this committee, including the acting chairman, and Mr. Broyhill, that saved me from having to make a self-serving statement about it.

Mr. BROYHILL. We have two votes when the amendment comes up, anyway.

Mr. WALTERS. Thank you.

Mr. LANDRUM. The hearings will be recessed until 2 o'clock, but the committee will convene at 12:30 in H-208 for the purpose of considering reporting the unemployment compensation bill.

With that, the committee is recessed until 2 p.m.

(Whereupon at 12:07 p.m., the hearing was recessed, to reconvene at 2 p.m., the same day.)

AFTER RECESS

The committee reconvened at 2 p.m., Hon. John C. Watts, presiding.

Mr. WATTS. The committee will come to order.

The first witness is Mr. Earl Cunerd. Come around, Mr. Cunerd. State your name and in what capacity you appear, and you may proceed as you desire, sir.

STATEMENT OF EARL CUNERD, EXECUTIVE DIRECTOR, UNITED CEREBRAL PALSY ASSOCIATIONS, INC.; ACCOMPANIED BY DR. ELSIE HELSEN, ATHENS, OHIO

Mr. CUNERD. Thank you, Mr. Chairman.

SUMMARY

POINT I

We support extension of Medicare benefits to those receiving disability benefits under the Social Security Act.

POINT II

We endorse the President's proposal in HR 14080 to increase benefits at least 10% and to provide for automatic benefit increases thereafter to meet future increases in the cost of living.

POINT III

We support the President's welfare proposals in HR 14173 concerned with the disabled which would:

- (A) Establish a national minimum welfare payment of \$90 per month.
- (B) Set national standards for State Welfare Plans.
- (C) Establish eligibility for welfare benefits by the use of a simplified statement of need.
- (D) Provide an option to states for direct federal payments of benefits.
- (E) Encourage concentration on increased social case work services at the state level.

We suggest that present provisions for the blind, namely, disregarding of earned income in the determination of need also be adopted for the severely disabled.

POINT IV

We oppose changes in Medicaid that permit states to reduce the scope and extent and care of services provided under their State Plans. We also oppose the delay until July 1977 the date by which states must provide comprehensive medical coverage to all persons meeting eligibility standards.

POINT V

We would favor some form of income assistance plan (similar to the family assistance plan) for those disabled persons who are attempting to earn their own way either in sheltered workshops or a low-paying marginal job in the competitive labor market.

POINT VI

We favor increased concentration of effort and increased authorization for funding for maternal and child health services, crippled children's services, maternal and infant care projects, and special project grants for health or school and preschool children. We feel these programs are extremely important for prevention of the birth of children with disabilities.

I am Earl Cunerd of Philadelphia, Pa. I am executive director of the United Cerebral Palsy Associations, Inc., with headquarters in New York City. With me is Dr. Elsie Helsen, of Athens, Ohio, parent of a 23-year-old cerebral-palsied son and part-time representative for United Cerebral Palsy Associations in Washington, D.C.

Mr. WATTS. We are delighted to have both of you with us.

Mr. CUNERD. Thank you.

We greatly appreciate the opportunity to appear before you today to share our comments and concerns about some of the changes proposed for the Social Security Act.

United Cerebral Palsy Associations, Inc., is a national voluntary organization of parents, concerned citizens, and professionals working in partnership to see that the care, treatment, and training services needed by the cerebral-palsied and their families are available. There are 304 State and local affiliates in 45 States and the District of Columbia.

DEFINITION OF CEREBRAL PALSY

Cerebral palsy is the general term applied to a group of disabilities caused by injury or damage to the developing infant brain. The damage results in impaired muscle control. In addition, the cerebral-palsied usually have one or more physical or mental defects. About two-thirds of the cerebral-palsied are mentally retarded. Approximately one-half have speech and communication problems. One-third have visual disorders; 20-percent have defects in hearing. An undetermined number have learning difficulties associated with perceptual and conceptual problems.

These disabilities can and do occur in any combination. Of the approximately 700,000 individuals with cerebral palsy in the United States, about 500,000 receive at some time in their lives services or benefits authorized by the Social Security Act under titles II, V, XIV, XVI, or XIX.

Fully appreciative of the demands on the committee's time and cognizant of the time allotted to us, we would like to limit our remarks to those sections of the Social Security Act which affect United Cerebral Palsy's two top priority areas of program need as determined by a recent self-study and evaluation of our national organization. These are:

(1) Prevention of cerebral palsy and other neurologically handicapping conditions, and early care of children suspected of having such disabilities.

(2) Services for teenagers and adults, particularly those whose handicaps render them unemployable. They have especially complex long-term care needs.

Since many bills have been introduced proposing changes in the Social Security Act which would affect the adult disabled, we would like to comment first on these.

I. EXTENSION OF MEDICARE TO THE DISABLED RECEIVING DISABILITY BENEFITS UNDER THE SOCIAL SECURITY ACT

Among the disabled are two groups who have an obvious and imperative need for both hospitalized and medical insurance. These are:

(1) Individuals who have become disabled in adulthood and qualify for disability benefits on the basis of their own earnings; and

(2) Individuals disabled from childhood and who qualify on the basis of their parents' coverage under social security.

As you may know, those who are severely disabled are not especially good insurance risks and they frequently cannot obtain hospital or medical coverage from regular commercial carriers.

Some of the young cerebral palsied adults employed in sheltered workshops have now worked long enough to qualify for disability benefits on the basis of their own earnings. However, even with a combination of wages and social security disability benefits, they do not earn enough to be self-supporting, although we encourage them to become as independent as their potential permits. They cannot afford the costs of medical and hospitalization insurance, even if it were readily available to them. Extension of medicare to this group of our population would give them access to better health care and, equally important, would give them one more step toward "making it on their own"—something they want very much to achieve.

Indeed, United Cerebral Palsy would like to see enactment of a Federal hospital and medical-insurance program, available to all seriously handicapped persons over 21 years of age, without regard to entitlement to monthly cash benefits. A bill providing such coverage, H.R. 287, has been introduced.

We should like to point out to the committee how extension of medicare would help families of the disabled in a very important way.

One of the most haunting questions the family of a disabled child lives with—from the time they finally realize the disability is a lifetime one—is, "What will happen to him when we die?" Lifetime care is expensive. However, many families do try to plan ahead so their disabled child will not become a public charge and be left with just one alternative—placement in a public institution.

In our present affluent times, some of these families are financially secure enough so that by pooling funds from several sources—insurance benefits, sale of family home, disability and childhood benefits, liquidation of other personal assets—they can establish a trust fund that may reasonably be expected to maintain a handicapped son or daughter in a small nursing home, group home or other suitable residential facility.

However, a primary threat to such planning is prolonged illness and/or hospitalization. Given today's spiraling health care costs, lifetime savings and assets can be depleted in short order. The fact is, seriously handicapped persons have unusual needs for health care. Even a dental extraction—something relatively minor for a nonhandicapped person—may, for someone severely disabled by cerebral palsy, become an involved surgical procedure requiring general anesthesia, a full operating room team and recovery in a hospital.

The disabled person with comprehensive medical and hospital insurance coverage written by a commercial insurance carrier is indeed a rare and fortunate individual. Extension of medicare to this group of handicapped persons would be of great help to those who are trying to help themselves.

II. H.R. 14080—THE ADMINISTRATION PROPOSAL TO INCREASE SOCIAL SECURITY BENEFITS

United Cerebral Palsy endorses H.R. 14080 as a means of easing the problem of providing adequate financial support for individuals who need long term care. The proposed increase of 10 percent in benefits will be helpful since the measure will also increase childhood disability benefits which are based on 75 percent of parents' benefits at the time of death, or 50 percent at the time of parents' retirement.

Even more helpful, of course, would be a provision for automatic increase in benefits to reflect future increases in the cost of living.

United Cerebral Palsy Associations, therefore, urge passage of both proposals.

III. H.R. 14173—WELFARE PROPOSALS

The primary resource for financing long term care for cerebral palsied adults is Aid to the Permanently and Totally Disabled. In the past, the level of support and standards for eligibility and care have varied widely from State to State. Therefore, we heartily endorse the provisions in title II of the Welfare Act, providing for a national minimum payment of \$90 a month and for the use of a simplified statement, to establish eligibility for benefits.

We would like to respectfully suggest, however, that in the interests of simplification and consistency, the provisions concerning income that may be disregarded in the determination of need, be the same for all categories of disabled persons as they are for the blind: namely, that the first \$85 per month of earned income plus one-half of the earned income in excess of \$85 per month be disregarded. As the bill presently reads, the severely disabled may disregard not more than the first \$20 of the first \$80 per month of earned income, plus one-half of the remainder thereof.

ALTERNATE PROVISIONS FOR DIRECT FEDERAL PAYMENTS TO INDIVIDUALS

We strongly favor the provision in title II, section 1605, that a State may enter into an agreement with the Secretary of Health, Education, and Welfare, under which he will, on behalf of the State, pay aid to the aged, blind, and disabled directly to individuals in the State under that State's approved plan.

This would not only provide a more acceptable way of delivery of the money payment, but it would also enable States to concentrate more effort and attention on the social services which this group of people, who have more than their share of life's problems, badly need.

IV. CHANGES IN MEDICAID

Turning to title XIX of the Social Security Act, United Cerebral Palsy would like to share its concerns about the recent changes that have been made under P.L. 91-56 and to show the tremendous potential this legislation has for helping to meet some of the long-term care problems of seriously disabled adults.

We are dismayed by the rider attached to H.R. 5833 (P.L. 91-56) which makes it possible for a State to reduce the scope of service provided under its State plan. We are also unhappy at the delay to July 1977 as the date by which a State plan must provide comprehensive medical coverage to all persons meeting eligibility criteria.

We had hoped that medicaid would develop on schedule so that by 1975 our families in all States might look to this resource for help in meeting long-term care problems.

In four States; namely, California, Washington, Michigan, and Minnesota, we have cerebral-palsied adults living in private residential placements and having a major part of this care paid for by medicaid funds. In California the facility is a wing that has been added to a

children's rehabilitation center. In Seattle, Wash., we have 30 adults living in a wing of a nursing home, who go out daily to sheltered workshop activities at our United Cerebral Palsy Association center. In Minnesota, we have a similar arrangement in a nursing home. And in Michigan, our affiliate has a residential program in a portion of a renovated hospital. Our affiliates provide the day-to-day program activity and see to it that other needed services are provided.

The alternatives to the development of such resources at the community level is institutionalization. Community care costs run from \$3,000 to \$5,000 per person, per year. Adequate institutional care costs \$8,000 to \$10,000 per person, per year. United Cerebral Palsy sees great potential for a program that assists in providing costs for extended care facilities within the community and would like to see the medicaid program phased in as originally scheduled.

V. INCOME ASSISTANCE

About half of the disabled adults in the United States who are employable live below the poverty line. Despite tremendous problems with transportation, architectural barriers, inadequate living quarters, and health problems, these plucky individuals prefer to maintain themselves on their own earnings. However, living costs for this group are higher, not lower, than for the able-bodied. Their needs for medical and dental care are greater, not less, than the needs of their nonhandicapped peers.

We would like to see some financial assistance plan developed for this group to supplement their meager earnings. We also favor, as previously stated, extension of health and insurance benefits to this group. To be disabled is surely enough of a problem without the added burden of poverty.

MATERNAL AND CHILD WELFARE SERVICES—TITLE V

We turn now very briefly to title V of the Social Security Act which authorizes health and other services to mothers and children and which has great potential for prevention of cerebral palsy as well as other handicapping conditions.

Although this committee is certainly not responsible for the continued under-funding of these programs, the committee should note that the recent 5-percent decrease in funding of all Maternal and Infant Care Projects, the Children and Youth Projects, Research in Child Health and Crippled Children's Services, is having a devastating effect in the field. Some of these programs have already made noticeable headway on reduction of infant mortality and associated reproductive casualties which produce damaged infants.

Forgetting for the moment the cost in human anguish of the birth of such handicapped infants, and looking at the financial cost of care alone, the hope for the future is in prevention. These programs should have top priority.

In the United States the lifetime cost of care plus lost wages for each person with cerebral palsy is an estimated \$75,000 to \$150,000. The cost to the Nation just in terms of lost productivity is a staggering \$1¼ billion annually. As a long-range financial investment alone, money

expended for these programs will produce significant returns: healthy mothers, who in turn will be delivered of healthy babies.

Prevention is not just a good investment. It is the best investment we can make in the most precious resource this Nation has—its people and its future.

In summary, we favor the proposals for change in the Social Security Act—titles II, XIV, XVI and XVIII. We are distressed by the changes in title XIX. We hope coverage under the Social Security Act will continue to expand until it is truly supportive and protective of those disabled individuals who, through no fault of their own, cannot provide for themselves.

We would like to close with two quotes from two of the President's messages to Congress which seem particularly appropriate. From Mr. Nixon's welfare reform message: "A measure of the greatness of a powerful nation is the character of the life it creates for those who are powerless to make ends meet." And from the social security message: "This Nation must not break faith with those Americans who have a right to expect that social security payments will protect them and their families."

We appreciate this opportunity to appear and be heard by your committee. And if you or your committee have any questions, we can answer, we will sure try to do it.

Thank you.

Mr. WATTS. Thank you for your very fine statement. We appreciate your being here.

Any questions?

Thank you very much.

Mr. CUNERD. Thank you.

Mr. WATTS. The next witness is Kenneth Graham of the Welfare Tenants Coordinating Committee.

You may proceed, Mr. Graham.

STATEMENT OF KENNETH GRAHAM, FIELD COORDINATOR, WELFARE TENANTS COORDINATING COMMITTEE, NASSAU COUNTY, N.Y.

Mr. GRAHAM. I am Kenneth Graham, and I am a field coordinator for the Nassau Welfare Tenants Coordinating Committee in Nassau County, Long Island, N.Y.

I apologize for not having mimeographed copies of my statement, but at our present state a mimeographing machine is a luxury that we do not enjoy.

I wish to speak in terms of welfare reforms and proposals.

First of all, I would like to bring to you the plight of 34,000 humans whose lives are being presently damaged by inadequate welfare policies, practices, and grants in Nassau County. I speak because the New York State Legislature as of July 1, 1969, in a time of inflation and rising costs felt it was their political duty to cut State welfare payments to balance a budget, as they termed it. In fact, they were taking food out of the mouths of children, their mothers, the blind, the disabled, and the aged.

We had hoped to have testify before you some of Nassau County's finest citizens who are presently receiving welfare. Again, costs and transportation problems prevented this.

To realistically assess the impact of these oppressive cutbacks in New York and the present state of welfare in an affluent suburban Nassau County, let me read very briefly some actual case histories.

Mr. A, a single person, 50 years of age, physically disabled, currently receives \$2.43 daily for food, clothing, and other basic needs. Under the new system in New York State with the cutbacks, he will receive only \$1.97 per day for food, clothing, and other basic needs.

Mrs. B, a mother with four children, ages 15, 13, 12, and nine, currently receives \$1.64 per person daily for basic needs, including food, clothing, laundry, toiletries. In addition, the family receives \$24 monthly for school lunches. Under the new system in New York State, they are cut back to \$1.47 per person daily, and the special grant for lunches is cut out.

Mrs. C, a 70-year-old woman on special diet under doctor's orders, currently receives \$2.43 per day for basic needs. She also receives a \$7.75 monthly grant to cover additional costs associated with her special diet and \$4.45 for emergency telephone service. Under the new system in New York State she will receive only \$1.97 per day for basic needs and will lose the special grants for the special diet and telephone services.

These are the people, thousands of them, in our county who shoulder inhuman economic existence. Considering the direct cutback along with an almost 5-percent rise in the cost of living and new sales taxes the poor and the welfare client once again are hit harder than any other citizen in New York State.

Second, I wish to express my concern over the growing misconceptions that our society continues to perpetrate about the poor and the welfare client in our Nation. I am concerned that a civilized nation still continues to blame the poor for their poverty. I am concerned about the completely inaccurate statements and attitudes that picture the welfare recipient as lazy, shiftless, and one who doesn't want to work. I am concerned that the poor and the welfare recipient are held accountable for their use of nickels, dimes, and quarters when other segments of our society, both governmental and private, continue to spend and often waste money on questionable items.

To this end I would urge this committee to call upon their fellow Congressmen to begin to educate their constituents at home in terms of the cruel, inaccurate stereotypes that the average citizen has about the welfare recipient. I am sure that any legislation and money spent in an educational program which seeks to do away with the popular myths concerning welfare recipients will be well spent. Present negative attitudes held by the majority of our citizens concerning the welfare recipient are certainly a part of the total welfare crisis we are now facing.

Concerning the administration's new welfare proposals, first of all, the goal providing every family an adequate income of \$1,600 for a family of four is not adequate. It seems AFDC families in Nassau County will get less money under this plan than they do now.

There seems to be no provision for food programs, no cost-of-living indexes, and most recipients in Nassau County must rely on the New

York State Legislature to bring up this minimum base to their present grants.

Judging from the present mood and attitudes of New York State leaders in terms of previous cutbacks, it seems doubtful they would be so inclined. There is the possibility that States like New York would probably have more leeway to treat AFDC recipients illegally and unfairly than they do now.

In my estimation \$1,600 is far below the poverty line and is thus inhuman. I would recommend a basic guaranteed minimum base of \$5,500 for a family of four along with a scale to provide for rises in the cost of living.

The Department of Labor, as well as AFL-CIO estimates that \$9,000 a year is needed for a family of four to live on in an urban city. I would recommend that the Federal Government either fund this \$5,500 base completely, or a large percent of this amount, and mandate States to pay the rest.

Concerning the work aspects of President Nixon's proposals, I would recommend that work be voluntary. Forcing people to work and to register their names is dehumanizing and has all the earmarks of stigmatizing people as do present welfare procedures. Carrying such a policy to its logical end, we would be approaching elements of slavery.

People who are on welfare will refuse to take part in any way in any degrading policy such as monthly registrations and forced labor. That small percentage, for example, of welfare recipients who are capable of working in Nassau County need only meaningful job opportunities for them to move off of welfare into the labor force. Motivation for work comes from job opportunities and training that is relevant, jobs that provide dignity and jobs that provide upward mobility.

I would suggest that minimum wages be set at least at \$3 an hour. I recommend also that any work incentive programs must take into account the job discrimination and racism that exists in the hiring and promotion practices in our both private and governmental industries.

Again, with all the emphasis on work as a solution for the welfare crisis, we must keep in mind that work does not provide a solution for the large number of welfare clients who are aged, disabled, blind, and who are children and mothers of these children. In this area is is grossly inhuman to force AFDC mothers to work regardless of the ages of their children. Raising children is a full-time job, and any woman who feels that it is her place to be in the home should not have that right taken away. To those women who upon assessing their personal individual situations believe that working is possible for them, then suitable day-care facilities should be provided.

Concerning day-care centers, which, of course, play a vital role in any work program, it is imperative that welfare recipients themselves play an active role in the planning and staffing of these centers.

To digress for a moment, one wonders to what degree welfare recipients were consulted or called upon in the planning of present welfare policies and legislation.

Concerning other aspects of the Nixon proposal, given the inadequate levels of funding, it is imperative that those under this program continue to use free food-stamp and food-distribution programs.

In conclusion, may I say that welfare in terms of our Judeo-Christian heritage is a moral right which people are entitled to in a civilized nation, entitled to in nonpunitive ways. There can be no higher priority in our society than the social and economic well-being of its people. Human needs should be our first priority.

Thank you.

Mr. WATTS. Thank you very much for your statement.

Any questions? Mr. Bush?

Mr. BUSH. Mr. Graham, what is the Tenants Coordinating Committee of Nassau County exactly?

Mr. GRAHAM. This is an organization that is not, of course, funded or part of the public welfare system.

Mr. BUSH. It is a voluntary organization?

Mr. GRAHAM. It is a voluntary organization consisting of a voluntary staff, nonpaid staff, such as myself.

Mr. BUSH. You are a volunteer helping these people in Nassau County?

Mr. GRAHAM. Yes. There is nobody on the staff who is paid. We work with local welfare groups in smaller towns in Nassau telling them of their rights, helping to protect them from certain practices that exist in the Welfare Department.

Mr. BUSH. The only thing is, I know the committee's time is valuable and yours too, but I am a little troubled by your recommendation of a \$3 minimum wage in the face of the testimony we have had of how counter-productive that would be in terms of those least trained for jobs and in terms of the young people. Most of the testimony around seems to indicate that a minimum wage at that level would make more unemployment rather than less, but your organization feels differently. Is that correct, sir?

Mr. GRAHAM. Yes.

Mr. BUSH. That is all, Mr. Chairman.

Thank you, sir.

Mr. WATTS. Any other questions?

If not, thank you for your testimony.

Mr. GRAHAM. Thank you.

Mr. WATTS. The next witness is Daniel W. Pettengill. Come around, Mr. Pettengill.

Please state your name and for whom you are appearing and those that are with you, and then you may proceed as you desire.

STATEMENT OF DANIEL W. PETTENGILL, VICE PRESIDENT, GROUP DIVISION, AETNA LIFE & CASUALTY; ACCOMPANIED BY JAMES A. DORSCH, WASHINGTON COUNSEL; AND JAMES H. HUNT, DIRECTOR OF GOVERNMENT RELATIONS FOR THE GROUP DIVISION

Mr. PETTENGILL. Thank you, Mr. Chairman.

I am Daniel W. Pettengill, vice president, Group Division, Aetna Life & Casualty. With me are James A. Dorsch, our Washington counsel, on my left, and James H. Hunt, our new director of Government Relations for the Group Division, on my right. I appear on behalf of my company.

Aetna is the largest private health insurer in the United States. It therefore has a vital interest in health care, its problems and its future. Aetna and other insurance companies recognize that the increasing complexity of the skills and equipment needed to perform the modern miracles of medical science and the increasing shortage of health-care manpower have created an upward spiral of medical-care costs. That spiral threatens the economic security of virtually every family in America.

As an aside, I would point out that in drafting testimony for today, we have avoided urging the cause of private health insurance, which has contributed so much to the field of health care. We have tried instead to reach for a constructive set of solutions to a major national problem.

Our proposals do, however, envision a continuing role for private health insurance companies, because we believe competition among them will provide the efficiency and flexibility essential for a sound solution.

I realize that the Committee on Ways and Means is basically concerned with financing and taxing. However, while financing health care is a serious problem, the fundamental health problem facing the Nation today is the inaccessibility of quality health care for much of the population and the unacceptability of some of the care that is available. The adoption of any plan that seeks to solve the financing problem—without at the same time seeking to solve the fundamental problem of the availability of quality medical care—not only will not be a solution but will make matters far worse.

Underscoring this view are statements made last week by Dr. Roger O. Egeberg, Assistant Secretary for Health and Scientific Affairs, and John W. Gardner, former Secretary of HEW. Dr. Egeberg said that it would be a mistake to introduce any unitary national system for health-care payments before the Nation had reformed its system of medical care. The extra burden of demand would swamp an already overtaxed system of medical care.

Mr. Gardner said that while the medicare and medicaid programs have gone far to relieve the elderly and the poor of the financial burden of health care, the programs have brought only a small increase in the availability of health-care services. He added:

The billions of dollars they (Medicare and Medicaide) have place in the hands of the health-services consumer—pressing against a system incapable of providing these services on an adequate scale—have produced a terrifying inflation of the cost of medical care.

Our Nation must adopt a coordinated set of programs to improve for all citizens the availability and acceptability of health care as well as the means of financing it. These programs should make maximum use of the private sector and judicious use of Government funds. To achieve those goals, Aetna Life & Casualty recommends the adoption of the programs which I shall highlight now.

In brief, these programs would:

- (1) Strengthen both the responsibilities and the financing of comprehensive health planning agencies.
- (2) Provide additional funds for meeting specific and growing health manpower needs.

- (3) Promote the development and use of comprehensive ambulatory care.
- (4) Improve cost controls while assuring quality care.
- (5) Extend the availability of health insurance to all and provide a new plan of catastrophe coverage.
- (6) Establish a National Advisory Health Council.

I. STRENGTHEN COMPREHENSIVE HEALTH PLANNING

Comprehensive health planning is essential if we are to use our large but not unlimited resources for the greatest good of both present and future generations. Planning is needed to identify unmet needs and to establish a rational order for meeting them. Planning is also needed to avoid unnecessary and costly duplication of facilities and services. Although some needs are common to all communities, others are not, and the priorities differ considerably. For example, some communities need to plan for additional hospital beds while others need to plan for elimination of excess hospital beds. Because local health needs are involved, planning must be done at the local level with support and coordination at the State and National levels.

For those reasons, Aetna Life & Casualty proposes that comprehensive health-planning agencies be assigned at least the following specific responsibilities:

- (1) To determine and assign priorities for the health needs of the community on a continuing basis and to publicize them.

- (2) To review all proposals for constructing new health-care facilities, for remodeling existing facilities, or for offering new health services that would require either significant capital outlays for equipment or hiring substantial numbers of scarce health manpower—and to certify the degree of need that the community has for the facility or service.

- (3) To review requests for Government loans or grants for health-care facilities, manpower, or services, and to advise the appropriate government agency whether the project for which the loan or grant is requested is one for which the community has an essential need—and, in the case of a grant request, whether that need has a high priority.

We also propose that the Federal Government give greater guidance and financial support to comprehensive health planning.

II. PROVIDE ADDITIONAL HEALTH MANPOWER

The shortage of health manpower is widespread, acute, and worsening. Until this shortage is relieved, health-care costs will continue to rise much faster than the overall cost of living. More important, until this manpower shortage is overcome, our Nation cannot hope to make quality health-care available to all.

In solving the health manpower problem, particular attention should be paid to training physicians who will provide primary care for families and to developing allied health personnel who will assist physicians in this work. Also needed are doctors trained in the special skill of managing teams of physicians and allied health personnel in health centers. Indeed, in some instances, it will be necessary first to

develop curriculum and secure the necessary faculty before it will be possible to train students.

Accordingly, Aetna Life & Casualty proposes:

A. That the Federal Government consolidate its various loan-grant programs for health manpower into a single program.

B. That this new program provide:

(1) That a student may borrow up to the full cost of tuition, room and board for such medical, dental, nursing, or other allied health professional training as the Secretary of Health, Education, and Welfare specifies as essential to relieve the health manpower shortage; and

(2) That, upon completion of his training, the student will have one-tenth of the total loan waived for each year of service within an area—rural or inner city—which is certified as needful of his service by the appropriate comprehensive health-planning agency and authorized by the Secretary of Health, Education, and Welfare.

C. That Federal grants be made to medical schools for devising curricula and securing faculty to train additional physicians skilled either in providing primary care or in managing teams of doctors and allied health personnel in health centers.

III. PROMOTE AMBULATORY CARE

Much diagnosis and treatment currently provided hospital in-patients could be more economically rendered on an ambulatory basis if adequate facilities and personnel were available. Thus, provision of comprehensive ambulatory care services is another urgent national need.

In some communities an existing group practice could be expanded to meet this need. In others, the hospital out-patient department could be reorganized, while in still others a brand-new facility may have to be established by the community. Properly-equipped ambulatory care centers could probably perform 25 percent of all the surgery now done on an in-patient basis as well as much of the diagnostic X-ray and laboratory testing.

The potential reductions in the total cost of care are substantial, even though the initial cost of establishing these centers will be considerable.

Accordingly, Aetna Life & Casualty proposes:

A. That a Federal program of loan guarantees be established to encourage construction of ambulatory care centers.

B. That Federal loans be made available to cover setup costs, with grants made in place of loans for centers established in poverty areas.

C. That benefits for ambulatory care be included in all governmental health insurance programs.

D. And that employers be urged to include ambulatory care coverage in group medical expense plans—with a proviso that an employer who has not done so within a reasonable period, say 5 years, could deduct for Federal income tax purposes only 50 percent of the money spent to provide medical expense benefits for employees and dependents.

IV. IMPROVE COST CONTROLS

Strengthening comprehensive health planning, providing additional health manpower, and promoting ambulatory care are all essential ingredients for improving the availability of health care and doing so at a lower overall cost. It is also essential that cost controls be introduced in order to slow the upward spiral of health-care costs.

Accordingly, Aetna Life & Casualty proposes:

A. That no Federal loan or grant for a specific health facility or service be made unless the project is certified by the appropriate comprehensive health-planning agency as an essential need, and, in the case of a grant, that the need is of high priority.

B. That reimbursement of health-care services under all Federal programs be subject to the following conditions:

(1) That care will be covered only in those health-care institutions which have a review committee of qualified physicians that effectively check whether the services rendered are of good quality and are necessary for the proper treatment of the patient, and whose management takes effective action with respect to adverse findings of the review committee.

(2) That the professional services of physicians and allied health personnel be subject to effective peer review and that no payment shall be made for any professional service which is found to be unnecessary.

(3) That no payment be made for that portion of a fee charged by a physician or allied health personnel which exceeds the prevailing level of fees in the community.

(4) And that the services of a health-care institution be paid for on a "controlled charges" basis and that no payment shall be made unless the institution uses controlled charges for all its patients.

Under the controlled-charges system, each institution would budget its expenses for the fiscal year and establish charges for services that should produce the income assumed by the budget. The cost of capital would be includable in the budget, and hence in the charges to patients, only to the extent that the capital expenditure had been approved by the applicable comprehensive health planning agency. The institution would file its budget and its charges with a reviewing agency composed of representatives of consumers, insurers, and health-care institutions.

Should the budget reveal that the institution apparently would not operate efficiently, in comparison with comparable institutions providing comparable services, or the charges appear out of line, the reviewing agency would request a revised budget and revised charges. Filed charges would be deemed to be acceptable by the reviewing agency unless it acted to the contrary within 60 days of the filing. The reviewing agency would be able, however, to request a prospective change at a later date. For valid reasons, budgets and charges could be revised during the year in accordance with the foregoing procedures.

V. EXTEND AVAILABILITY OF COVERAGE TO ALL

I have emphasized that our major problem is to improve the availability of acceptable health care. We must not, lose sight, however, of

the fact that at least 11 percent of the population under age 65 has no health insurance at all and that the poor need assistance with financing and adequate level of health-care coverage. Solving this latter problem need not be as costly to the Government as it might appear.

At least 60 percent of the population under 65 is covered under employer-sponsored group medical-expense insurance programs, some quite rich in scope. It is logical to build on this private health insurance in extending the availability of health insurance to all. For example, group plans could cover permanent part-time employees and even temporary employees where the temporary employment is expected to be at least a calendar quarter. When employment is suspended due to layoff or labor dispute, some provision for continuation of the group coverage could be made. Most important of all, when an employee becomes totally disabled, he could be permitted to continue his coverage until becoming eligible for medicare.

A. Minimum standards for group medical-expense plans

Accordingly, Aetna Life & Casualty proposes that the Federal Government limit the deductibility of an employer's expenditure for medical-expense benefits for employees and their dependents to 50 percent instead of the present 100 percent if the plan does not include all of the following features:

(1) That eligibility for coverage include all full-time and all part-time employees working at least 20 hours a week for at least 13 weeks of the year. Inclusion of the insurance industry's model coordination-of-benefits clause is recommended to avoid costly over-insurance.

(2) That coverage continue for at least 1 month during a layoff or labor dispute with no increase in required employee contributions, with provision for continuation for up to 11 more months during such layoff or labor dispute subject to the employee's paying the full cost of the coverage.

(3) That coverage continue during a period of illness or injury up to a maximum of 6 months with no greater employee contributions being required than would have been had the employee remained actively at work. If at the end of the 6-month period the employee were totally disabled, coverage would be continued for as long as total disability continued but not beyond the date he first becomes eligible for benefits under title XVIII of the Social Security Act. The employee would not be required to contribute more for such continued coverage than he would have paid had he remained a healthy, active employee.

(4) That coverage continue for dependent children who are totally disabled, provided the child were insured under the plan prior to age 19 and became disabled prior to that age. This continuation would remain in effect until the child recovered or became eligible for benefits under title XVIII of the Social Security Act. The employee would not be required to contribute more for such coverage than would have been required were the child a dependent under age 19.

Admittedly, the foregoing does nothing to help the hardcore unemployed, the near-poor whose employers do not provide group medical-expense insurance, and the self-employed who are uninsurable because of poor health. These three classes of people need Government assistance in financing their health care. This assistance would be more

acceptable if it were in the form of a subsidy for private health insurance rather than the present welfare type of payment.

B. Uniform insured plan for poor, near-poor, and uninsurables

According, Aetna Life & Casualty proposes:

(1) That the Federal Government encourage each State to make available, through a reinsurance pool underwritten by all carriers, a uniform plan of health-insurance benefits to the poor, near-poor, and uninsurables.

(2) That the uniform plan be operated like a group plan with all the administration being performed by one carrier or a set of carriers chosen by the State with the concurrence of the Secretary of Health, Education, and Welfare.

(3) That the benefits provided by the plan be at least the minimum benefits specified by the Federal legislation creating the program. (See exhibit I.)

(4) That poor families would be defined in the law as those whose adjusted income for the preceding calendar year was less than a specified dollar amount, which would be uniform for all States. The adjusted income would be gross earnings less the sum of the \$600 personal exemptions allowed in the income tax law. This would avoid the rigorous means tests which some States have applied in administering the medicaid program and simplify and reduce the cost of administration.

(5) That the upper income limit for the poor be the lower income limit for the near poor and that there be an upper income limit for the near poor specified in the law and uniform for all States. The near poor would be required to make a contribution towards the cost of their coverage, which would be a percentage of the adjusted income for the calendar year on which their eligibility for coverage was based. The percentage would range from a very nominal figure for those who are just above the lower income limit to an amount which approximated the full cost of the premium for those just below the upper income limit for the near poor.

(6) That an uninsurable person would be defined in the law as one who had attempted to purchase private health insurance providing the minimum benefits prescribed by law for State uniform plans and who had either been completely rejected or offered the coverage at a premium rate in excess of that required by the State's uniform plan for uninsurable people. Each uninsurable person electing to participate in the State's uniform plan would be required to pay a contribution reflecting in part his very high claim costs with the balance being borne by the pool as a whole. If the uninsurable individual were a member of a family, the insurable members of the family would secure whatever private coverage they desired for themselves from the carrier of their choice.

(7) That participation in the uniform plan would be voluntary except that the State would be obligated to include any family to whom cash assistance is provided.

(8) That the policy year of the pool program would run from July 1 of one year through June 30 of the following year. Premiums, contributions, and coverage would be provided for the entire policy year regardless of when the individual actually applied for coverage

during that year. (This provision is necessary since some people will not apply for coverage until after they become sick.)

(9) That all carriers, profit and nonprofit, licensed in the State to write medical expense benefits would share any losses suffered by the pool and would be allowed an appropriate risk charge for assuming this risk.

(10) That the administering carrier or carriers would set the premium rates for the uniform plan for each year with the advice and consent of a non-man actuarial committee appointed by the Governor of the State from among actuaries recommended by the other carriers.

(11) That the State's cost of the program would be the excess of the premiums charged by the pool over the contributions made by the near poor and the uninsurables. This cost would be shared by the Federal Government on a basis related to the difference between the per capita income of the states and the per capita income of the Nation, with a minimum Federal contribution of 65 percent for all States whose average per capita income was higher than the national average and with a maximum Federal participation of 90 percent. To the extent that a State wished to provide more than the minimum benefits required by the law, it would be permitted to do so. However, the extra premium required for the additional benefits would be shared by the Federal Government at a rate equal to 75 percent of its sharing rate for the minimum benefits.

We believe that each family is responsible for insuring its own medical expenses with assistance, where appropriate, from the Government. At the same time, we recognize that no insured plan can soundly provide benefits for every single dollar of medical expense that a family might incur. Thus, the Nation needs a catastrophe medical program under which each family would be responsible for its own medical expenses up to a portion of its income, or up to the amount of its insurance, if greater. The State would pay any medical expenses incurred in any given year in excess of the family's responsibility.

Obviously, such a program could not be instituted overnight by any State, even with Federal assistance. Instead, the program should be phased in gradually, starting with the poor, then the near poor, and finally the balance of the population.

Before embarking on an open end medical expense program of this type, Congress should be aware of the tremendous cost of providing room and board for those people, primarily the elderly, who are not physically able to feed and clothe themselves or take care of their daily personal needs. Congress should determine whether this is a medical problem, the cost of which should be covered under the State catastrophe programs, or a social problem which could more effectively be met through some other means. The problem exists. It is an enormous one. The question is how best to solve it.

C. Catastrophe medical expense program

Specifically, Aetna Life & Casualty proposes:

(1) That the Federal Government encourage each State to set up a catastrophe medical program by agreeing to share the cost at a rate equal to 75 percent of the sharing rate applicable in that State for a pool program of minimum benefits as described in section B above.

(2) That the Federal Government specify that its sharing would initially be available only with respect to the poor and would specify

a time schedule under which its sharing would become available for the near poor and finally the entire population.

(3) That the Federal Government would specify the types of medical expenses eligible for inclusion for purposes of Federal sharing initially, and provide a time schedule for including additional expenses.

(4) That the amount of the annual deductible under the catastrophe program—the amount of medical expenses the family would be responsible for before it would be eligible to have the balance of its expenses paid for by the catastrophe program—would be set by Congress in the enabling legislation. The deductible would be such as to be zero for the poor and then rapidly increase to give the average worker ample incentive to secure adequate health insurance which would at least cover his deductible. An illustrative scale of deductibles is attached hereto as Exhibit II.

VI. ESTABLISH A NATIONAL ADVISORY HEALTH COUNCIL

Health care and health-care problems are so complex today that no President and his Cabinet can be fully informed. It seems desirable, therefore, that the President and his Cabinet have available the advice of a group of experts in the provision and insuring of health care who would be independent of political pressures.

Accordingly, Aetna Life & Casualty proposes:

(1) That a National Health Advisory Council be appointed by the President of the United States.

(2) That the council be of limited size, say nine members, each serving for a 3-year term with the initial terms on a staggered basis.

(3) That the council encompass a broad spectrum of those associated with the delivery, financing and receipt of medical care, including in particular a consumer representative and a State administrator of health programs.

(4) That the council be responsible for keeping the President and his Cabinet advised about the major problems in the field of health care and for recommending: the priorities that should be established for allocating available funds or manpower to solve such problems, the agency that should administer any given governmental health-care program, and the governmental health-care programs that should be revised or discontinued because they are ineffective or no longer serve an essential need of the Nation.

Our present health-care system is not working as well as it should. Some people do not have access to acceptable care because of income or place of residence. All find that good medical care is becoming increasingly expensive. The shortage of health-care personnel grows more critical daily. Catastrophe looms behind the approaching crisis.

We are confident that these problems can be solved by bold, imaginative action. The comprehensive and interrelated programs proposed by Aetna Life & Casualty build on the strengths of all the elements of our present system. They combine the unsurpassed flexibility, innovativeness and managerial skills of the private sector with the unique economic capacity of the public sector. Out of this cooperative endeavor would arise a new partnership of unprecedented scale and potential.

We are prepared to enter such a partnership. We invite Federal, State and local governments, our fellow insurance companies and all

other interested parties from the private sector to join us in this partnership.

(The documents referred to follow:)

EXHIBIT I

ILLUSTRATIVE BENEFITS

FOR THE STATE UNIFORM PLAN

Ambulatory Care

(a) A health check-up examination, biennially for people ages eight through sixty-four, annually for children under age eight.

(b) Annual dental prophylaxis and any necessary fillings for children ages eight through fourteen.

(c) All necessary immunizations for children under age eight; also, any necessary immunizations for pregnant women.

(d) Physicians visits in his office or an ambulatory care center up to a maximum of twelve per year.

(e) Surgery and anesthesia essential thereto.

(f) Radiation therapy.

(g) Diagnostic x-ray examinations and laboratory tests.

Institutional Care

(h) Thirty-one days of semi-private hospital care per year.

(i) Sixty days of skilled nursing home care for convalescent purposes per year.

(j) Ninety home care services per year when provided as part of an approved home care program.

(k) All necessary physician's services rendered on a day for which a benefit is payable for institutional care.

EXHIBIT II.—AETNA'S PROGRAM TO IMPROVE THE AVAILABILITY, ACCEPTABILITY, AND FINANCING OF HEALTH CARE FOR ALL IN THE UNITED STATES

ILLUSTRATIVE EXAMPLE OF DEDUCTIBLES FOR FEDERALLY SHARED STATE CATASTROPHE COVERAGE (FORMULA

INCOME FOR PRIOR YEAR

Adjusted income (gross income less \$600 for each Federal income tax exemption)	Deductible.
Less than \$1,000.....	0.
\$1,000 to \$1,999.....	50 percent of excess over \$1,000.
\$2,000 or more.....	\$500 plus 100 percent of excess over \$2,000.

	Deductible									
Gross income.....	\$2,000	\$3,000	\$4,000	\$5,000	\$6,000	\$7,000	\$8,000	\$9,000	\$10,000	\$15,000
Number in family:										
1.....	\$200	\$900	\$1,900	\$2,900	\$3,900	\$4,900	\$5,900	\$6,900	\$7,900	\$12,900
2.....	0	400	1,300	2,300	3,300	4,300	5,300	6,300	7,300	12,300
3.....	0	100	700	1,700	2,700	3,700	4,700	5,700	6,700	11,700
4.....	0	0	300	1,100	2,100	3,100	4,100	5,100	6,100	11,100
5.....	0	0	0	500	1,500	2,500	3,500	4,500	5,500	10,500
6.....	0	0	0	200	900	1,900	2,900	3,900	4,900	9,900
10.....	0	0	0	0	0	0	500	1,500	2,500	7,500

Note: If the benefits of any insured plan owned by the individual or family were greater than the formula deductible the catastrophe coverage would be excess to the insured benefits.

Mr. WATTS. Thank you very much for your appearance and excellent statement and for bringing out some concrete ideas for us to think about.

Any questions?

Mr. SCHNEEBELI. Yes.

Mr. WATTS. Mr. Schneebeli.

Mr. SCHNEEBELI. Mr. Pettengill, you have some very good specific examples here. Have you discussed these with other carriers in your health field to see whether they agree with your approach? Is this rather an industry approach, or is it unique to your company?

Mr. PETTENGILL. Regrettably, sir, time has not permitted me to discuss this with my associates in the business. However, I have meetings scheduled the balance of this month to do so, so that I hope that your committee will eventually be able to secure the reaction of other companies.

Mr. SCHNEEBELI. I think that is quite important to see whether this is your lone approach to this or whether you have a lot of cooperation from the other health companies in the insurance field.

Mr. PETTENGILL. I realize our industry is large and diverse, but I am hopeful that there will be a fair amount of support, sir.

Mr. SCHNEEBELI. Will you make that information available to us, then, during our deliberations in executive session?

Mr. PETTENGILL. Yes, sir.

Mr. SCHNEEBELI. Mr. Pettengill, are you aware of the proposals that the AMA made earlier this week and the type of insurance that they recommend for medicaid, the 21-to-65 age field?

Mr. PETTENGILL. I regret, sir, that I haven't had time to study their proposal.

Mr. SCHNEEBELI. They have quite a comprehensive proposal for private-carrier participation financed through Federal tax credits that would amount to a starting point of \$12 billion, which is quite an impressive and expensive start for an organization such as the AMA to recommend. And I would be interested in the reaction that your company and possibly your industry might have to the AMA proposal.

Mr. PETTENGILL. I would be glad to furnish them.

(The information to be supplied follows:)

AETNA LIFE & CASUALTY,
Hartford, Conn., December 1, 1969.

Mr. WILBUR MILLS,
Chairman, Committee on Ways and Means,
U.S. House of Representatives, Washington, D.C.

DEAR MR. MILLS: On behalf of Aetna Life & Casualty, I wish to thank you and the other members of the Committee on Ways and Means for having permitted me to present on November 6, 1969, Aetna's views on improving the availability, acceptability and financing of health care for all.

Among the questions asked me at the time of my presentation, were two for which I requested permission to reply in writing. This letter is the promised reply.

The first question was whether Aetna Life & Casualty's proposed program was supported by other insurance companies. On November 6, 1969, our testimony had not been submitted to the Health Insurance Association of America. Since then, it has been so submitted, and I am pleased to report that it has evoked real interest among the member companies. More importantly, our proposed program is being given intensive study by a special committee of the HIAA. We will advise you of the outcome on the HIAA's deliberations.

The second question was what are Aetna Life & Casualty's views on the American Medical Association's proposed "Health Insurance Assistance Act of 1969." Our views are outlined in the balance of this letter.

We believe the American Medical Association should be commended not only for its resourcefulness in devising a nationwide program of financing the cost of comprehensive hospital and medical insurance, but also for its recognition that adequate health care ought to be a basic right of all Americans, regardless of personal financial circumstances.

We are pleased to note that the AMA proposal recognizes the imperative need to include in any plan of reform incentives which encourage lower-cost

ambulatory care in lieu of high-cost in-hospital care. The AMA proposal would do this through a \$50 deductible applicable to in-hospital expenses only. We question whether this approach is an effective way to get existing group health insurance plans amended to include adequate benefits for ambulatory care.

We also not with approval the elimination of the complex means test and the use of a simple income test as the basis for eligibility. We believe, however, that it would be more equitable to base any annual subsidy of health insurance on amounts of "adjusted gross income" that vary by size of family than on the amount of actual tax. This is especially so as between those who own their own homes and those who rent, and as between single persons and married persons.

The AMA proposal focuses only on the financing of adequate health insurance. No complementary programs are put forth to develop additional health care manpower, to encourage the organization of ambulatory health care centers, and to control escalating health care costs. Simply to provide more money to buy scarce services, is to add more fuel to the fire of inflation.

Considering just the financing problem, it is not clear from the AMA proposal that health insurance would be available to all, even with the proposed tax credits and certificates. The bill provides that a "qualified medical care insurance policy" would have to be made available without regard to "any pre-existing health condition." This seems to imply that the underwriting of risks by the various carriers would not be permitted. However, as a practical matter, no one carrier or group of carriers can afford to accept all the uninsurable risks. Hence some pooling mechanism would have to be set up to spread the coverage for persons in poor health among all carriers on an equitable basis. The AMA proposal neither requires that such a pooling mechanism be created, nor suggests how it might be established and operated.

The AMA proposal is complex, due in part to the choice given between a tax credit and a health insurance certificate. For example, 1970 health insurance premiums paid by use of a certificate would generally involve a certificate based on the individual's income tax return for calendar year 1969. May such 1970 premiums then be taken as a credit on the individual's income tax return for calendar year 1970? If they may not, then the government has an additional policing job on its hands. There is also the questions of how long to permit a certificate to remain valid. For example, may a certificate based on a 1969 income tax return be used to pay premiums in 1973?

The apparently wide-open nature of the packages of benefits that insurers could offer will make even rough estimates of the cost of this proposed program very difficult to calculate. Also, state and local governments could be left to shoulder a heavy burden of uninsured but essential medical expenses in the event that the packages sold to the poor were quite modest in scope. Indeed, this burden could be even greater than that now borne by the state and local governments. Such results do not seem desirable.

We also have the following technical comments with respect to the AMA proposal:

(1) The "Basic Coverage" excludes coverage for home health care and for care in an extended care facility and hence presumably will create pressure for extended stays in hospitals among those who do not have "Supplemental Coverage" that includes benefits for these less expensive types of care. It would seem advisable that some benefit for these two types of care be included in the Basic Coverage with additional benefits being permissible under the Supplemental Coverage. Also, some clarification of the term "other personal health services" under item (4) of the Supplemental Coverage would seem advisable. Is "provider" used in the broadest sense or in the limited context of Medicare?

(2) The Basic Coverage, Part II, covers "all medical services, including diagnostic and therapeutic, *provided* by a doctor of medicine or doctor of osteopathy ..." (underscoring added). Does this exclude such services when lawfully rendered by paramedical personnel *under the supervision* of such physicians?

(3) We would question the need for a "plateau" in the curve of percentage credits at 20%. A more uniformly descending schedule of tax credit percentages would seem to be preferable.

We hope the foregoing comments will be of assistance to the Committee.

Sincerely,

DANIEL W. PETTENGILL,
Vice President, Group.

Mr. SCHNEEBELI. The day following the AMA appearance, incidentally, Dr. Hall, who is a Member of Congress and also a medical doctor, had his own limited approach to this AMA approach, which would probably cost half of what the AMA proposal would cost. And it might be more in line with your thinking, as it probably is with ours.

I would also be interested in knowing in our present medicare program to what degree have the private carriers participated as agents in the medicare program and to what degree has Blue Cross, Blue Shield. Is there any breakdown of the figures today on how much of this you participate in as the intermediary?

Mr. PETTENGILL. I believe, sir, that there are five insurance companies participating in part A. Regrettably we only have about 5 or 6 percent of the total of part A.

Mr. SCHNEEBELI. Five or six percent?

Mr. PETTENGILL. Right.

With respect to part B, I believe there are 14 commercial insurance companies participating. And they have, I believe, about 45 percent of part B.

Mr. SCHNEEBELI. This, then, has been a business pickup for your companies. It is not insurance, I realize. You are merely auditing. Is there any profit in it to your company?

Mr. PETTENGILL. The law, or at least the interpretation of the law, does not permit us any profit whatsoever, sir. So our rendition of this service is a public service.

Mr. SCHNEEBELI. At cost?

Mr. PETTENGILL. At cost.

Mr. SCHNEEBELI. You don't do it for free. It is at cost.

Thank you very much, Mr. Chairman.

I would appreciate it if we could then have your reaction to the AMA proposal as well as what the other carriers think of the proposal that you have just given us. I think you have given us a lot to think about.

Thank you very much.

Mr. PETTENGILL. Thank you.

Mr. WATTS. Any further questions?

Mr. BUSH. Mr. Chairman, I would like to join Mr. Schneebeli. The only thing I would argue about is whether we need another health council. We have so many of them around with different names on them, and I don't know that we need any more advice of people doing the same thing. That is the only argument.

I think they have a lot of darn good ideas here and Mr. Pettengill made an excellent statement.

Mr. WATTS. I do too.

If there are no further questions, thank you for your excellent statement. I think you have brought forward some concrete proposals that need a lot of study on our part.

Mr. PETTENGILL. Thank you, sir.

Mr. WATTS. The next witness is Mr. Urie Bronfenbrenner.

STATEMENT OF URIE BRONFENBRENNER, PROFESSOR OF PSYCHOLOGY, HUMAN DEVELOPMENT AND FAMILY STUDIES, CORNELL UNIVERSITY

Mr. BRONFENBRENNER. I have copies of my statement, Mr. Chairman.

Mr. WATTS. Please give your name and in what capacity you appear, and you may proceed as you desire.

Mr. BRONFENBRENNER. My name is Urie Bronfenbrenner. I hope that is the most complicated thing about what I shall say.

I am professor of psychology at Cornell University. My major field of specialization is the study of human development and, in particular, biological and social factors affecting human development.

I have conducted studies in many parts of the world on this problem, and that is what brings me before your committee.

As a specialist on human development, I am concerned, Mr. Chairman, with the impact of this proposed legislation on the next generation of Americans. There are provisions in this bill which, depending on their final form, will influence for better or for worse the capacity of millions of children, about one-third of all the children in our Nation, to develop into productive and responsible citizens. This prospect is of especial consequence for America's future in the light of certain destructive developments currently taking place in our society.

Although I am sure you are aware of these developments, I feel some obligation as a specialist to underscore their seriousness. This, in turn, requires me to speak briefly of matters which, on first blush, might appear to be far removed from the issue of welfare legislation. Nevertheless, I believe that on hearing them, you will agree that they deserve greater priority than some other, more obvious considerations.

As I have said, by profession I am a behavioral scientist. I specialize in the study of what is called "socialization"—the process through which the newborn infant is gradually transformed into a member of society, in other words, the process of making human beings human.

As a specialist on this process, I am deeply troubled. The seriousness of my concern is perhaps best conveyed by an analogy. Suppose you were an astronomer studying the solar system and, as you examined your own scientific observations and those of your colleague, you began to see some clear indications that the solar system was falling apart.

That is the situation in which I find myself. There is a growing body of scientific evidence that the process of making human beings human is breaking down in American society. The signs of this breakdown are seen in the growing rates of alienation, apathy, rebellion, delinquency and violence we have observed among the youth in this nation in recent decades. And the indications are from the evidence that these trends will be continuing at an increasing rate. The cause of the breakdown are, of course, manifold, but they all converge in their disruptive impact on the one institution that bears primary responsibility for socialization in our society—the American family.

As I have written elsewhere: Children used to be brought up by their parents. . . . While the family still has the moral and legal responsibility for bringing up children, it no longer is given the power

or opportunity to do the job. It is not that parents no longer love their children or want to take care of them, but that our society has imposed pressures and priorities which in effect remove the parent from the child, and vice versa, leaving the responsibility for child-rearing to others, or—all too often—to no one at all.

We live today in a society segregated not only by race and class, but also by age. The children's hour has become the cocktail hour. Urbanization, child labor laws, the abolishment of the apprentice system, commuting, centralized schools, zoning ordinances, the working mother, welfare legislation, the delegation and professionalization of child care—all of these manifestations of progress have operated to decrease opportunity for contact between children and parents, or, for that matter, adults in general.

The decline of active involvement of parents in particular and adults in general in the lives of children has been documented in a series of comparative studies, which my colleagues and I have conducted, and others as well, examining differences in child-rearing practices both across time and culture. The trend is especially marked in the United States, and it contrasts most sharply with the Soviet Union, in which we have carried out comparable research.

In the U.S.S.R., as you may know, programs for children, especially for the very young, have the highest priority and "vospitanie," for "upbringing," is virtually a national hobby.

The reduction of parental involvement in American society takes on crucial significance in the light of the findings of research on the nature of the forces that are most influential in shaping the development of the child. Specifically, these findings indicate that the most potent agents for facilitating the psychological development of the child, including the child of poverty, are the persons with whom the child has developed intensive and enduring emotional relationships—namely, his parents, relatives, and other persons, both children and adults, with whom he becomes closely involved on a one-to-one, day-to-day basis. The younger the child, the greater the importance of the intensive, enduring, one-to-one relationship.

A second principle, equally supported by the research findings, follows from the first: Any appreciable, enduring improvement in the child's development can be effected only through an appreciable and enduring change in the behavior of the persons intimately associated with that child.

It was because of the force of these principles that those of us who were engaged in the design of Head Start—and it was my privilege to be in that number—placed such a strong emphasis on parent involvement. It should be understood that what is crucial about parent involvement is provided neither by classes in parent education nor by appointment of parents to advisory committees, but by creating opportunities for and encouraging parents to engage in meaningful interaction with their children both at the center and, especially, at home.

The converse of the foregoing principles is equally powerful. It implies that any measure which has the effect of preventing at least one parent from establishing and maintaining enduring patterns of interaction with the child undermines the capacity of the child to develop emotionally, intellectually, and socially.

It is in the light of these considerations that I now turn to an examination of the provisions of the proposed Family Assistance Act and their potential impact on families and children.

To begin with, there can be no question that, from this point of view, the bill represents a significant improvement over existing legislation. In addition to setting a basic minimum across State lines, it introduces two long-overdue reforms of especial significance for family functioning.

1. Research from the days of the depression to the present has documented the destructive effects of inadequate income on family functioning, especially the capacity of man and wife to act effectively as parents. The recognition that such effects are no less debilitating when the inadequate income comes from wages rather than from welfare represents a major step forward in social legislation.

2. The adverse impact of father-absence on the development of children, especially boys, is well documented in the research literature. The removal of the inhumane eligibility requirement that the household receiving welfare be without a father can be expected to reduce not only present family frustration but also future costs for compensatory education, welfare, and delinquency control.

At the same time, there are a number of features of the bill, as presently written, which are likely to have the very opposite effect, for they set up situations which, by being unfavorable to the development of the child, risk turning a potentially productive member of society into a social and economic burden. Fortunately, such a probability can still be reduced, or even reversed, by appropriate amendments as indicated below.

1. The present bill takes an all-or-none position with respect to the mother's working. That is, she either works full-time or not at all. Yet from the point of view of the child's development, a far more desirable situation, at least through the primary years, if not longer, is one in which the mother works only part-time, so that she may have ample opportunity to care for and interact with her child. Specifically:

(a) For the school-age child, the effect of the present legislation will be to increase further the large number of "latch-key children," who, having no adequate supervision at home, are swept up in the activities of the peer group and become victims of the often destructive social pressures which such groups exert on their members.

I might add in this connection that we have conducted research on this problem, both on Soviet children and American, and the contrast is not one to our benefit.

(b) Although under the present legislation the mother of a preschool child is exempt from registration, the greater immediate (and long-term) advantages of registering (in terms of increasing a rock-bottom income while having the child in day care) can be expected to lead a substantial number of mothers—especially those without other wage earners in the family, to opt for full-time training and work. This, in turn, would severely limit the mother's time and capacity to engage in meaningful interaction with her preschool child either at the day-care center or at home.

(c) Those mothers of preschool children who choose not to register are, under the present legislation, deprived of opportunities for train-

ing, and—if they are the only able-bodied adults in the family—also of day-care facilities for their children.

(d) As illustrated by the preceding point, the present legislation discriminates against mothers who do not have a husband or other able-bodied adult living in the home. The mother of a school-age child need not register and work if she has a husband, but must do so if she hasn't. The mother of a preschool child, who is the sole potential breadwinner, may choose not to register. But then she is not eligible to enroll her child in the day-care facilities authorized under this bill. In either case, it is the child of the husbandless mother who is still further deprived.

All of the foregoing problems could be ameliorated by changing the all-or-none regulation to one that permits the mother to engage in half-time training and work.

It is, of course, true that opportunities for part-time work and training are difficult to arrange, that it is easier to implement an all-or-none policy. But the basis for welfare should not be administrative convenience but human need. Especially when the concern is for America's children, we should do not what is expedient but what is right. Specifically:

(1) While it is not desirable for mothers of preschool children to work full time, a mother could spend half time in training work and still give the needed attention to her child, particularly when the child is over 3 years of age and enrolled in a day-care program stressing parent involvement, through which the mother could learn new skills in caring for and stimulating her child's development. Moreover, if mothers of preschool children could earn half-time wages, this would materially reduce the public cost of this phase of the program.

(2) The mother of children over 6, by being able to come home from work by the time her children returned from school, could provide more adequate supervision and, in general, function more effectively as a parent.

(3) Opportunities for part-time training and work could be made available to the mother irrespective of whether or not she had a husband, thus eliminating the discriminatory feature of the present bill with respect to mothers and children in single-adult families.

2. The present bill provides for child-care services without stipulating standards, such as those federally mandated in Project Headstart, which insure a comprehensive approach, including health, education, and social services, as well as provision for encouraging parent involvement both at the center and in the home. Without such standards, there is the danger of a narrow approach in which parents are effectively excluded from participating in the program, and activities are limited either to a rigid emphasis on school-type skills, or free play, or simply sterile custodial care.

The provisions on child care in this bill need to be strengthened by indicating minimal standards for the operation of programs in these respects.

3. Finally, although the present bill purports to provide a basic minimum income for families of a given size, regardless of the State in which they live, in point of fact there will be an appreciable number of families who will not be receiving the designated minimums. This comes about because of the penalty provisions in the bill.

Thus, for a family with two able-bodied adults, the basic minimum is provided only if one parent, typically the father, either works or is in job training. If, for some reason, the father refuses training or work offered to him, or is unable to hold a job, the family income is automatically reduced to \$500 below the established minimum and it is the children who suffer.

The obvious solution to this problem is to maintain basic minimums irrespective of the father's training or working status while perhaps increasing the incentive to reregister by raising the \$30-per-week training allowance. The extra cost entailed would be defrayed in part through the savings made in permitting mothers of preschool children to work part-time. (See above.)

There are, of course, other problems with the present bill and other solutions. But in terms of present knowledge about human development, the ones I have mentioned are the most critical. In conclusion, I would stress that the changes I have proposed would have the effect not only of insuring more humane treatment of our disadvantaged citizens and their children but also reduce appreciably the number of Americans on welfare rolls in the years ahead.

At the same time I wish to emphasize that the passage of this legislation, even in its most desirable form, would still leave untouched many of the most crippling problems of our Nation's children. So long as we continue to tolerate the avoidable damage dealt by hunger, by inadequate prenatal care, squalid housing, and a host of other destructive conditions—which, by the way, are not tolerated by our principal competitor in the world, the Soviet Union—so long as we allow the present situation to persist, it is today's children—and tomorrow's cities—who will bear the disabling scars of our indifference.

As our heritage has warned us, "The sins of the fathers shall be vested upon the children even unto the third and fourth generations." (Exodus 13:7.)

Thank you, Mr. Chairman.

Mr. WATTS. Thank you very much for your statement.

Mr. SCHNEEBELI?

Mr. SCHNEEBELI. Sir, I am very impressed with your approach to this job, and it is quite apparent that you are a professional in this field. And I agree with you that it is so important to the future of our country.

In part of this you talk about standards such as they were incorporated in the Project Headstart, and there are no standards in the proposed bill we have here.

Mr. BRONFENBRENNER. That is my understanding, sir.

Mr. SCHNEEBELI. How are these standards working out that have been incorporated in Headstart?

Mr. BRONFENBRENNER. I wish I could say satisfactorily. About all I can say for them is that they are working out much better than would be the case if there were no standards.

Mr. SCHNEEBELI. Could you suggest to this committee a change in the standards that are presently incorporated in Headstart, a change that would make them better for use in our proposed program?

Mr. BRONFENBRENNER. I believe I could, sir.

Mr. SCHNEEBELI. This is a much more comprehensive field. Headstart is limited, and frankly might have been a good experimental trial run on the problem we are confronted with here.

I think we have to capitalize on what we have learned from Headstart, and you seem to be very professional in this field, as I have indicated, and I think you would do a service to the committee to recommend such standards as you think should be changed in planning for our present problem.

Mr. BRONFENBRENNER. Mr. Schneebeli, thank you very much for raising that question. It is one in which I am very much concerned.

As you may know, there is other legislation pending in both the House and Senate which outlines child-care programs and standards, and I am very much involved in seeing to it that those standards are spelled out in some of these bills, so I am very sympathetic.

I would be happy to respond to any request from this committee.

Mr. SCHNEEBELI. Is there any legislation that covers children to a more comprehensive degree than this bill?

Mr. BRONFENBRENNER. Not on the books.

Mr. SCHNEEBELI. I should think this would affect the lives of more children, more directly and a greater number, than any program that Congress is apparently concerned with, and I think we certainly need standards in this, and should benefit from what we have learned from Headstart and make it applicable in this program.

Mr. BRONFENBRENNER. I would be happy to prepare such a document that would outline what these standards might be.

(The document referred to follows:)

An excellent statement of standards, originally developed in connection with Project Head Start, is found in a document entitled "Federal Interagency Day Care Requirements," issued by HEW. In essence, the aim of these standards is to ensure that child development programs provide a high level of stimulation and individualized attention and do not degenerate to the level of sterile custodial care. The Secretary should have explicit authority to apply these standards in all child care programs receiving Federal funds. In addition, the following changes should be introduced in present legislation:

1. Eligibility should be explicitly ensured for participation in child care programs of children whose mothers are working only part-time.
2. The Secretary should have explicit authority to provide child care programs for children of school age where this is deemed necessary.
3. Priority should be given to child care programs that have been coordinated with the total effort in behalf of children in a given community.
4. Provision for parental involvement in the child development must be designated as an essential feature of all child care programs.
5. For all pre-school children, especially the very young, the health component should be an integral part of the child care program, and not left to be furnished as a separate component provided by another agency on a cost-for service-base. All too often, the fact that health services are legally available from some other source is taken as a substitute for the actual provision of such services to the child. Moreover, with young children, it is not sufficient to give services for cost only when the need becomes apparent. Regular observation and examination of the child is necessary in order to identify health problems before they become serious and irreversible.

The reasons for urging inclusion of the foregoing provisions in legislation are indicated in the main body of the testimony.

It should be emphasized that the setting of standards becomes an empty gesture unless an effective mechanism of enforcement is provided, and unless there is qualified professional leadership at the local level for organizing and supervising the program and providing necessary training for all personnel. The highly desirable use of non-professionals in child care programs can become ineffectual, and even harmful, in the absence of competent professional guidance and supervision on the part of the senior staff.

Mr. CONABLE. Would the gentleman yield?

Mr. SCHNEEBELI. Yes.

Mr. BRONFENBRENNER. I know the name Conable. John Conable was my classmate.

Mr. CONABLE. He is my brother.

I have some concern, here. It seems to me that one of our problems in such areas as day care is that we set our standards so impossibly high that we never achieve them, and the net result is that we leave things exactly where they were. Is it better to leave things the way they were?

Admittedly in the best of possible worlds we would like to have everybody with day care readily available at the highest possible standard. Is it better to leave things as they were, or to make some effort to move ahead by giving people the dignity of work, giving them an opportunity to work with something less than the highest possible acceptable standards?

Our standards in New York State for day care, for instance, have let us to the position where public day-care centers are considerably more expensive than private ones, and there just are not any public ones.

Mr. BRONFENBRENNER. Mr. Conable, the standards which I regard as optimal are the standards that are maintained in any reasonable family. They are not expensive standards to achieve. What they require is precisely the kind of thing you are talking about.

We have to enable people to be family members. They cannot be family members if they don't have the income, if they don't have a job, if they don't have dignity, and if they don't have the time to spend with their kids.

I believe that this matter of parent involvement, and allowing parents to be parents is the most important single thing that we can do, and at the present time our legislation very often, and our way of life, of course, even more, makes this impossible.

Now, let me mention in this connection the statement that was made to me by Soviet colleagues, because they have been experimenting in this area, and as you know, some years ago introduced boarding schools. Now they have moved away from boarding schools.

I asked a distinguished Soviet colleague why. Of course there are many reasons. They are very expensive. But he said fundamentally you cannot pay a woman to do what a mother will do for free.

To me, that is the heart of any program. The mothers have to be able to be there, not all the time, but enough so that they can be mothers, and their kids can know them, and they can learn what they can do with their kids. That is the mother's important element.

Many of these other things that cost so much money are not as vital as these things.

Am I being clear?

Mr. CONABLE. Yes, and I thank you for your answer. It is very responsive, and I think it is a good answer.

The same thing is reflected in our State, for instance, in our tendency to get rid of the institutional type of child care for orphans, and go instead to foster homes.

Mr. BRONFENBRENNER. Exactly.

Mr. CONABLE. I would assume that you would agree with Mr. Burke. He has had a great campaign on here to try to get more Federal contribution to the problem of foster care in the kind of home environment that is desirable to the emotional development of a child.

Mr. BRONFENBRENNER. I would certainly agree with that.

Mr. CONABLE. Yes. We have virtually no Federal contribution to this, as you know, historically, and it is something that in a State like our is a tremendous burden on State government, simply because of the great bulk that has to be picked there, rather than the kind of contributory programs that we have with respect to other aspects of welfare.

Mr. SCHNEEBELI. Sir, Governor Rockefeller was here last Friday, and I had a colloquy with him about the cost of setting up the necessary number of day-care centers to cope with this problem.

We already have 3.8 million mothers working, who have need for this, and we are trying to add 450,000 additional to the roll. That is 4¼ million, and we only have facilities available for half a million, so we have this big gap, big void, and we are trying to fill it.

He said that in New York State alone it would cost \$500 million, and nationally \$5 billion, to just establish the necessary facilities in order to cope with this problem of day-care centers.

Have you any comment on this cost?

Mr. BRONFENBRENNER. Yes. I have a comment on the cost.

Mr. SCHNEEBELI. Do you think it is rather accurate, and is it rather staggering, as well; isn't it?

Mr. BRONFENBRENNER. I cannot speak to the accuracy, because my end of things has not been concerned with the financing of these matters, but I can speak to the matter in this way.

It is my feeling that the kind of day-care centers that are needed could be provided much more economically if we recognized that the parents are our most important asset in the running of these day-care centers, not only parents, but older children, and I would mention in this connection that one of the most important and powerful ways of developing a sense of responsibility and social identity in an older child is to give him responsibility in relation to a younger child. We used to do a lot more of that.

These day care centers could incorporate older children. They could incorporate senior citizens.

What you need is professional direction. The person working with the child does not have to have a master's degree. Somehow we have gotten into the state in our country where no one except somebody with a master's degree is regarded as fit to have dealings with a child. I think that is defeatist. Civilization has gotten along rather well without these people with master's degrees in dealing with a child.

Mr. SCHNEEBELI. I think you are very practical.

Who is going to operate the day care centers, as far as you are concerned? Should it be the Government, as a nonprofit institution? Should it be a profit institution, or a quasi-type?

Mr. BRONFENBRENNER. I am not clear, when you say "operate." Do you mean where the money is coming from?

Mr. SCHNEEBELI. No, which organization supervises, administers. Who is in charge?

Mr. BRONFENBRENNER. Who is in charge? My own view is that the more you can get the local people to have the responsibility for their kids, the better.

Mr. SCHNEEBELI. That is correct.

Mr. BRONFENBRENNER. It is they who care about their children, more than anybody else.

What is needed, however, is a set of standards, and the purpose of the set of standards is not so much to punish people who don't come up to them, but to set the standards up there because most parents want good operations for their kids.

Mr. SCHNEEBELI. Could this be an area for the school board to enter because we have already established a system of approach to handling children, and here, if we set up in the town of let us say a quarter of a million people an entirely new bureaucracy to take care of day care centers, we are not only having an expensive but probably a duplication as well.

It seems to me that since the school boards were affiliated slightly in Headstart, or at least they were in my area, and I think did a good job, could the school boards to some degree get into this matter of operating day care centers?

Mr. BRONFENBRENNER. Yes, and no.

There is a problem with the school board. That is that the tradition of the American school, dating back from the separation of church and state, which in effect made the school the subject matter area and left the child and character and behavior and values to the family and the church, has resulted in a school system in the United States which is very much focused on learning of skills, and which does not appreciate adequately, very often, the health considerations, the human relations considerations, the comprehensive approach which I have mentioned.

In particular, they are not ready to treat parents as people who have any right or knowledge to deal with kids.

That is the problem.

Mr. SCHNEEBELI. In our area, we have gone from the primary school system to the kindergarten, to the prekindergarten. It seems to me as though we are pretty close to the problem, with our present school system, and rather than set up an entirely separate bureaucracy, we already have a competent system available.

I am not recommending it since I do not know enough about it. I am looking for a reaction. It would then seem to me that there are a lot of alternatives.

Mr. BRONFENBRENNER. I would buy your notion, and in fact that is what is happening in Headstart, as you know. Many of these are run by schools.

But it is very important to add to the school board other people from the community who would balance this emphasis, so that you would have some people there from among the parents group. You would have some people there who represent the medical profession and know-how. You would have some people there who would know about the recreation problems in that community, and you would have some teenagers and young people involved in that.

Mr. SCHNEEBELI. But it could be a section of the school board particularly responsible for this type of thing?

Mr. BRONFENBRENNER. But I would not want the authority vested solely in the school board.

Mr. SCHNEEBELI. I am trying to think of some efficient system.

Mr. BRONFENBRENNER. You don't want a new bureaucracy, and it is entirely desirable not to have that.

Mr. SCHNEEBELI. I yield.

Mr. CONABLE. One last question, Mr. Chairman.

The Russians are ahead of us in many ways because of their willingness to use subprofessional types far beyond what we do?

Mr. BRONFENBRENNER. That is right.

Mr. CONABLE. And this is true when you talk about medicine or the education of kids?

Mr. BRONFENBRENNER. Child care.

Mr. CONABLE. Do you have any suggestion as to how we can change the emphasis in our society on constantly upgrading skills, with the result that we find it more and more difficult to deliver the services?

Mr. BRONFENBRENNER. I have so many suggestions, Mr. Conable, that I am embarrassed, because once you start me on this thing, I have given it a good deal of thought.

Mr. CONABLE. It seems to me that this is a problem we are constantly having to fight. Every group becomes a profession, and every profession wants to upgrade its skills, and exclude those who might be of assistance to that profession.

I take it you don't favor putting HEW in charge of Headstart.

Mr. BRONFENBRENNER. I am not sure how you mean that.

Mr. CONABLE. It tends to put the educational types in control.

Mr. BRONFENBRENNER. I say if that were the Office of Education, I would be worried about it.

Mr. CONABLE. But HEW, you feel, can do it?

Mr. BRONFENBRENNER. I think HEW is OK. It depends on how it is done.

I think that if the Office of Child Development in HEW is given the muscle that the President's message said it would have—but that is not what is happening today with respect to that Office—if it had it, that would be the place.

Mr. CONABLE. Yes, I see. Thank you.

I realize that is an impossible question, but I worry about that.

Mr. BRONFENBRENNER. I think there are many things we can do, Mr. Conable.

For example, in many other countries at the high school level there is explicit training for both boys and girls in how to work with kids, and the games you can play, and the things you can do with them, and so on.

Another kind of thing that we could do, for example, is if you place Headstart centers near high schools, or right in the high school area, so that some of the courses that have to do with kids are related to the Headstart center, so that we develop not only a profession but a generation that knows how to deal with kids.

It is very impressive to see Soviet teenage boys handling young children. They are marvelous with them. Our kids don't know what to do.

Mr. CONABLE. Despite the fact that the Soviet family is considerably smaller than the American family.

Mr. BRONFENBRENNER. And perhaps even because of it, because a child is a more valued creature when you don't have so many of them.

Mr. CONABLE. Thank you, Mr. Chairman.

Mr. WATTS. Mr. Burke.

Mr. BURKE. Dr. Bronfenbrenner, I just wish to comment on your statement. It contains so much common sense. It is an excellent statement.

I believe you have made a study in depth on this subject, you support many of the things that I have been advocating on this committee for a long time.

I agree that it would cost the Government much less money to invest in the mother, rather than investing outside, because with the mother's love for the child, they are going to extend themselves a lot more.

Mr. BRONFENBRENNER. It is a natural.

Mr. BURKE. I think since World War II there has been a tremendous trend toward the mothers leaving the homes, and we see this behavior that is taking place today in the country, where these youngsters are being left alone, and the mother is out working, and the father is working, and the child is left to itself all day, sitting before the TV and radio and mixing in with all kinds of companions, with practically no supervision. Suddenly they grow up, and people are shocked at their behavior.

I believe a lot of it could be traced back to the lack of maternal supervision.

Mr. BRONFENBRENNER. And that in turn, sir, could be traced to the fact that in our society we give very little respect, very little support, and give very little concern to parents as parents, and to what they are doing. That is regarded as something that you almost do in your spare time.

It is the fault of the larger society, not the parents. The parents are simply doing what the society tells them to do.

As I put it to my students, nowadays a good mother is the one who picks the right camp for her children.

Mr. BURKE. In fact, I have taken an interest in a lot of the juvenile cases that take place up in my district, and very seldom is a parent taken to task for the violations that the youngster has committed. Very seldom is the parent today held responsible.

You can understand this because of the parents trying to keep up with the Joneses, buying two cars and having a television in every room, and having a nice summer place to go to, and a trip during the wintertime.

I recall back prior to World War II that there seemed to be more dedication and devotion on the part of the parent, because the mother was home with the children. The mother knew where the child was all the time.

It is not unusual today to go out on the streets at night at 1 or 2 o'clock in the morning and see a 12 or 13 year old child out roaming around.

Maybe I am old fashioned, but I often wonder how much control they have over a youngster like this, allowing him this permissive activity, and where that child is headed—I don't just mean that evening, but for the rest of his life, if he is allowed to just roam the streets and take off for a couple of days and be missing all night.

There is a lack of concern in our communities today, and I think that is the trouble with some of the proposals that we have here. They say, "Maybe if we get all these children in the day care centers."

Day care centers can be very good. They can have the right people, but sometimes you don't get that interest in the child that you get from the mother.

I don't believe that we could spend enough money. We could spend billions of dollars, and farm all these youngsters out into day care centers all day, but when it is all said and done, I believe the real, intense interest in that particular child is the interest shown by the mother.

The mother might have a few faults, but among even those with faults I find that some of them have raised some wonderful children, and, while they might have been misdirected in their ways, they still show an effort to raise that child properly, and try to put it in the right direction.

MR. BRONFENBRENNER. I want to make sure we understand each other on this: I agree with you, but I caught in your statement the implication that it was the parents who were in a sense to blame. I don't believe that is correct.

It is not the parents who are to blame. It is the larger society which says to parents, "This is the way to do it."

You remember Longfellow's *The Children's Hour*. The children's hour has become the cocktail hour. Parents are doing what the society tells them to do.

Now, that is why it is important to have at the national level, at the level of the President, and at the level of all our activities, and in terms of industry, I think it is very much to industry's interest to say, "We recognize that some of our major problems are stemming from the fact that we don't let the people in our industry function as parents. We regard parenthood as important. From now on, we are going to change the pattern of our industry. We may not be able to pay as high wages."

But I have told some of my colleagues in industry, "I know how you can get some of the best men for less money: If you let them be the kind of parents they want to be. They cannot be, because you are scheduling all these social events for the parents, and not the kids. They have to be away weekends, and so on."

This brings me to the important point. If we were not to have these day care centers, we would be worse off.

We need to do something which says we have to do things differently. The day care center is a place for parents, both parents, to participate, because we think kids are important.

Parents ought to be involved with their kids. We need to reteach parents what they can do with children, because parents don't know, unless we have some kind of an institution which again flags the importance of children, which makes it exciting and prestigious to spend time with kids, and unless we reteach our population what you do when you spend time with kids.

If we were just to say, "Leave the child with the mother," this mother will still continue to do what the TV program tells her to do, and what we all tell her, that it is better to go to work than stay with the kids.

We need the day-care program, but the worst thing would be if these were taken over by professionals who say, "Get out. We know how to raise your kids better than you do."

I hope your committee is aware of one of the most dramatic pieces of research by Harold Skeels, in which he took some retarded kids, too retarded to be adopted, and placed them in the wards of an institution for mentally retarded women with IQ's less than 80.

He had a control group of half which he left in the institution.

Those children brought up by retarded women turned out to have normal development, became productive workers. The children who remained in the institution, the day care institution, are still there today, 30 years later, or are dead.

One of the children who was placed in the ward with mentally retarded foster mothers graduated and has a graduate degree from the University of Minnesota in the field of child care.

This underscores what you were saying, that you don't have to be a genius to bring up a kid.

Mr. BURKE. I believe all we need is common sense.

Along the line of what you have mentioned here before about the responsibility of business, our society seems to be in a status right now where everybody gets to work at 9 a.m., and gets through at 5 p.m.

If you study these drivers going home over the expressways, going out of the urban areas, you see a lot of people driving home bumper to bumper, under real pressure conditions.

It would seem that industry, and the Government, too, could stagger their hours, and maybe some of these people would get home to meet their children with a much better disposition than they do.

They drive home in the rush hour, 45 minutes or an hour, and when they get home they are very short-tempered. They have worked hard all day, and then they are going to face the children that they have not seen all day. These are some of the things that are going on.

There is an awful lot that can be done by society to improve conditions. Mass transportation would help in a lot of these areas.

Mr. BRONFENBRENNER. Go back to public transportation.

Mr. BURKE. And get people to sit down on the train or rapid transit car and read the paper, and when they arrive home at night, they are a little more relaxed.

Today, a person gets behind that wheel, and is growling at the fellow in front of him, and the fellow behind him is blowing the horn.

You have done an excellent job here today, and I want to commend you.

Mr. BRONFENBRENNER. Thank you very much.

Mr. WATTS. Are there any further questions?

If not, Mr. Bronfenbrenner, thank you for appearing.

Mr. BRONFENBRENNER. Thank you.

Mr. BURKE (presiding). Our next witness is Morris Richardson.

Mr. CONABLE. Mr. Chairman.

Mr. BURKE. Yes.

Mr. CONABLE. I would like to say that Mr. Richardson is a valued constituent of mine. He has had a great many valuable suggestions on the administration of extended care and Medicaid that he has made to me in the years that these programs have been in existence, and I suggested that he come down here and testify. I am grateful that he accepted my suggestion and came down.

He is a man who is not looking out for himself in the suggestions he makes, but trying to improve the operation of the system from the point of view of one who has to live with it.

I think he has some very practical suggestions to present to us today, and I am very pleased to be able to welcome him here.

Mr. BURKE. You come very highly recommended by one of the very able members of this committee.

STATEMENT OF MORRIS RICHARDSON, ROCHESTER, N.Y.

Mr. RICHARDSON. I hope I can live up to them.

Mr. BURKE. I hope so, because Mr. Conable is very conservative in his recommended actions.

Mr. RICHARDSON. Oh, is he?

Mr. Chairman and members of the committee, my name is Morris Richardson, and I reside at 24 Jackie Circle East, in Rochester, N.Y. I am the owner and operator of a small nursing home in an adjoining suburban town. I have constructed another nursing home in the area, and my wife has been co-administrator and operator of another small nursing home for over 5 years. In many ways I have been close to and familiar with the operation of nursing homes, and the way in which medicare and medicaid relate to the operations of such homes. In addition, I serve on the board of directors of a nonprofit nursing home in the same area.

My first major point is that the Congress, by making money available through the Social Security Administration for medical care, did not automatically increase the capability of the country to deliver more medical care. It did not increase the number of physicians, nurses, or other medically trained persons, nor did it increase the number of hospitals, nursing homes, or other medical facilities. Before the passage of the act, the physicians and other persons of whom I speak were fully occupied and in general hospitals and other medical facilities were also fully occupied.

The training of more physicians is a long-term project, commencing with the creation of new medical schools, training of instructors, and equipping of these schools, requiring a leadtime of many years before the end product becomes available to society. In addition, only the most talented of our students are capable of mastering the courses and surviving the training required. As our population grows, this number increases proportionately, but it does not increase absolutely unless the medical profession becomes more attractive and appeals to a larger number of our talented people, or unless the standards are lowered.

Medical facilities such as hospitals, nursing homes, and medical equipment can be expanded much faster than the personnel can be trained. Therefore, in order to make more medical services available to the general public, a different system of utilizing existing personnel must be considered. The medical system must be changed so as to allow greater participation by nurses and medical technicians. This participation could be under the supervision of licensed physicians. A major part of the time of many physicians is wasted performing functions that do not challenge their talents nor use their training to any meaningful degree.

Perfunctory medical inspections for entry into schools or camps, for work permits, for insurance companies, for civil service examinations, and civilian employment are examples of such waste of time. Nonphysicians could be taught to use and make basic interpretation from much medical equipment. Many of our laws requiring various documents to be certified by physicians should be examined with regard to the necessity of this certification.

The purpose of the medicare and medicaid enactments, as I understand it, is to make funds available to the persons who are covered, on the theory that if such funds are available, they will be able to purchase medical care with them.

In order to purchase more medical care, the system should be designed and administered in such a way as to encourage the training of more medical personnel, and the construction of more medical facilities. From actual experience, I would like to describe the situation which exists with respect to the subject of obtaining more medical facilities.

Within this area, I specifically turn to nursing homes or extended care facilities as they are designated in the medicare legislation. If anyone here wanted to build a nursing home in my area, and he were willing to comply with every known building and program requirement, he would not be able to proceed.

For some reason, the law, and not necessarily medicare or medicaid, has chosen to protect all existing facilities by not allowing qualified new facilities to be built unless there is, in the judgment of somebody, an actual need for the facility. The effect of this is to provide a virtual monopoly for existing facilities, regardless of their cost or efficiency.

The situation is aggravated because the present medicare and medicaid systems are set up to pay existing facilities whatever their costs are. All facilities must meet the same standards and furnish the same services. Yet, in my area, some nursing home facilities are paid \$13 per day by medicaid, and other nursing home facilities are paid \$28 per day for the same service.

The net result of this situation encourages high costs, since every cost which can be documented is paid for by the Government. Since the Government is paying the cost on an insurance approach, the individual receiving care loses all true interest in what the cost is. He does not have to pay anything, and could not care less.

Two requirements of free enterprise have really been eliminated: the ability of any person who thinks he can do a good job to enter the field has been legislated away, and the market place survival of the organization which furnishes the optimum combination of a good service at efficient cost has been eliminated, because there are no cost-conscious customers to make hard-nosed appraisals of what they are receiving for their dollars.

Let me not imply that costs are being pushed up simply to obtain more money. The legislation, or administration of it, is largely responsible for high costs by what is euphemistically referred to as "conditions of participation."

The handling of this concept has produced some unbelievable paradoxes. For instance, in my area a medicare patient is deprived of any realistic choice of nursing home facilities. Out of approximately 40 nursing homes, only five have met the so-called conditions of participa-

tion for medicare. As a practical matter, the length of stay in such homes for a medicare patient is such that there is no room on a day-to-day basis to accommodate new medicare patients.

However, a medicaid patient, under a welfare approach, can gain entrance to any of the 40 homes, and the result is that a welfare patient has his choice of any nursing home in the area.

Another consequence of regulation is that medicare patients sit in hospitals waiting for nursing home openings. They can only go into the five nursing homes, which have met the conditions of participation, even if there were beds available in the other 35 homes. Therefore, the result is that the medicare patients, who have recovered enough to move into nursing homes, remain in hospital beds. In cost this means that the individual is using a \$50 a day bed in a hospital, when he could be using a \$20 a day bed in a nursing home. This is a costly way to administer a program.

Just as serious a problem is that this patient is occupying a hospital bed and is keeping others out of the hospital.

Is there any substance to justify some of the requirements of participation? I suggest that there is not. This is especially true of some of the program requirements. A requirement of a full-time administrator in a small, or even medium sized, nursing home is, in my opinion, unjustified, and I am intimately familiar with the amount of administration required.

The administration of a 60-bed nursing home by a skilled administrator does not require more than 6 hours per week. Other program requirements, such as the amount of time that a dietitian and consulting personnel must be on staff, are further examples of unrealistic use of the concept of "conditions of participation."

This means that in this area the Government itself is driving up costs of medical care, by requiring unneeded services in medical facilities. Furthermore, and I hope you realize how serious this is, the private, paying patient in the same home is having his cost driven up. If there are 20 medicare patients in a 60-bed home, and this home is forced to have a full-time administrator because of medicare requirements, the medicare patients will only pay for one-third of the administrator's cost and overhead, and two-thirds of this cost is passed on to private, paying patients.

If we are trying to make medical care available to more people, it would be better accomplished by using more fully the facilities which are now in existence, and gradually increasing standards for qualification as experience proved the standards to be necessary. If medicare care is to be expanded by the order of magnitude which the medicare and medicaid programs seem to contemplate, then it seems unescapable that lower levels of care will have to be accepted. We cannot put all of America in the Americans.

One of the other results of the system which is bothersome is that the so-called nonprofit facilities in our area almost uniformly have much higher costs than the profit facilities. Therefore they receive more dollars per day per patient to perform a service without any profit, than does a similar facility which must make a profit.

These nonprofit organizations also operate without carrying their share of the local real estate tax burden and in many instances pay no sales tax on many items. This combination of factors which indicate

that a nonprofit facility should operate at a lower cost than a profit one make it incredible that it should in fact turn out to be the other way. And it is incredible, and needs to be changed.

Medicare should be limited to only recuperative patients in an extended-care facility. Why should a medicare patient who is a non-recuperative stay in a hospital for 100 days at \$50 a day, if he could spend 80 of those 100 days in a nursing home at a fraction of the cost?

Why should not a medicare patient go into the market and choose the facility which will provide care of an acceptable level at the cheapest cost?

I do not believe that just because the Government is providing part of the funds for a program that the program must become uneconomical. Actually, there is some doubt as to medicare, that the Government is anything more than a collector of funds, and surely this should not bring about the difficulties inherent in a program actually administered by Government.

My suggestions to improve the situation are these, and they are not necessarily in the order of importance:

1. With respect to nursing homes or extended care facilities, if a patient is determined by a physician to need any such facilities, he should be reimbursed for costs in accordance with a predetermined schedule of reimbursement. The patient should be free to purchase in his community such medical services as he desires. If he chooses a nursing home facility which charges more than he is reimbursed, he should be free to make up the difference from his own funds. If the charge is less than the reimbursement schedule, of course he is only reimbursed for his actual cost. Since this freedom is already in existence for hospital care, I am hard pressed to see any reason why it cannot be extended to the nursing home service.

2. If we are to have health insurance for the aged, the conditions of participation for nursing homes should be in line with existing facilities, so that medicare patients will have beds available in the community at a low level of expense brought about by competition.

Further, the patients should qualify for health insurance when they need medical services in the usual sense of that phrase, and not receive coverage only when they need an intensive level of care. Such an approach renders health insurance illusory and is contrary to the accepted community understanding of health insurance.

If we are to make medical care available to more people, the law should not raise the standards by requiring administrative and overhead costs where they are not needed. The direction should be to make more, rather than fewer, beds available.

3. No distinction with respect to nursing home facilities should be made between recuperative and nonrecuperative patients.

4. If the system is continued on the basis of reimbursing providers of services for their costs, this reimbursement should be for costs actually incurred, and not for assumed payroll or other costs.

5. Every effort should be made to enable medicare patients to stay on a self-disciplined program of medical care. The system as presently administered tends to propel the marginal insured medicare patient into a welfare status, with the attending disadvantages to all concerned.

6. Unrealistic conditions of participation should not be used to drive up the cost of medical care of nonparticipants, namely, the general public.

I want to take this time to thank the committee for the opportunity to appear and give testimony. Within the area of my competence and experience, I shall be glad to attempt to answer any questions or speak in more depth to any of the points which you find of particular interest.

MR. BURKE. Are there any questions?

MR. CONABLE. I have one or two questions, Mr. Chairman.

MR. BURKE. Mr. Conable.

MR. CONABLE. You understand I think, Mr. Richardson, that one of the reasons that the public programs have tended to shy away from trying to put too much pressure on competition among nursing homes or extended care facilities, or hospitals, either is a fear that there be a reduction in the quality of the care as a result of this competition, that cost cutting would result in a reduction of service.

Now, is there a course available to us here to cut costs without reducing the quality of care or eliminating benefits?

MR. RICHARDSON. Yes, there really is a course available, and some of the earlier testimony today pointed out that the Kaiser Foundation was moving at about a 30 percent reduction in costs on hospital care.

MR. CONABLE. What sort of things, other than what you have already mentioned in your statement, would you like to add, there?

In changing the law, I don't want to unleash a whole battery of inspectors to come around and check the quality of care all the time, and I am sure you don't want that, either, because such people can become officious and create all kinds of problems. That is one reason why we have not done this.

You are not advocating that sort of thing, I take it.

MR. RICHARDSON. No, no. I think we should have a very good set of standards, and in our particular case, in New York State, prior to medicare legislation, they rewrote the code, and they tightened it up almost sufficiently so that it would meet the conditions of participation.

Then social security came along, and did not approve the greatest majority of New York State nursing homes.

MR. CONABLE. You said, "in our area."

MR. RICHARDSON. Well, New York State, or Monroe County, or any given specific area.

When this became tightened up, or these nursing homes became nonacceptable to medicare, this automatically stops the medical delivery system in providing care to anybody. The hospital beds get loaded up.

Medicare cannot move out into the other levels of care, and the whole delivery system bogs down, and this is our present state.

MR. CONABLE. Do you believe there are hospital beds now in our area filled with people who should be in extended care facilities?

MR. RICHARDSON. Absolutely. At one time just recently there were over 200 people in hospitals that did not belong there.

MR. CONABLE. How do you know that?

MR. RICHARDSON. I know this from talking with several doctors in the area, and having them tell me, and identifying perhaps the Rochester General Hospital with 47, and St. Mary's Hospital with

36, and Strong Memorial with maybe 80, and this was the census that I took.

Mr. CONABLE. Does that run up the cost of medical care substantially? I should think it would, because, of course, that means that you have people in expensive beds when they should in cheap beds.

Mr. RICHARDSON. This is a question we have to answer very carefully.

On the surface, this may look to be so, but I would like to point out that the average length of stay, statistically, on a medicare patient was 6.8 days.

Now, if you put a patient into a hospital bed and block this bed up for 60 days, you have then prevented 10 people from processing through this bed. If the 10 people had processed through the bed at \$20 to \$25 a day, your costs would then be \$200 to \$250 a day.

I make this point quite slowly and quite carefully, in that even though people would think this is the high cost of the hospital day care per days of care, this actually could almost be interpreted as an economic measure.

Mr. CONABLE. Well, your theory seems to be that people are not getting the service we intended to deliver. Is that right?

Mr. RICHARDSON. They are not getting the service.

Mr. CONABLE. What are they doing, dying at home?

Mr. RICHARDSON. Or in the hospital.

They are not getting the service of going out into the nursing home or extended care field and getting the services that medicare told them they had, because the facilities have not been certified.

But a Medicaid patient, which is on welfare, moves out and gets the service.

Mr. CORMAN. Would the gentleman yield?

Mr. CONABLE. Yes.

Mr. CORMAN. I think that is terribly important. I had not thought of it at all before.

The fact of the matter is that in your hypothetical case, there are 10 people who need the care.

Mr. RICHARDSON. Yes, sir.

Mr. CORMAN. And under the present system, only one gets it, so that we are saving money at the expense of the 9 people who need the care but cannot get it because they cannot be processed through that hospital bed.

Mr. RICHARDSON. This is the tragedy of the situation.

We said care would be available. This was the intent, I assume of titles XVIII and XIX, and you have the situation blocked up so that the whole system is not delivering, and then you get another group of people claiming we must have more hospital beds, and this is not the case, because technically we could unload the hospitals the minute we had more nursing home or extended care beds that were just acceptable.

I am not saying we have to build them. All I have to say is that the present system, as we now have it, should be utilized and not restricted or choked off at any one point.

Mr. CONABLE. Mr. Richardson, I want to come back to this, because you seem to be saying that we have a short-term crisis here in the availability of medical facilities, yet you say you don't want to reduce the quality of care.

What can we do quickly to extend our medical delivery system?

Mr. RICHARDSON. Well, in the system we will have to perhaps have four or five categories of care acceptable to social security, of which an extended care facility is only one category. There are such things as a regular license.

Mr. CONABLE. Custodial types, for instance?

Mr. RICHARDSON. All right. Let us start from an extended care facility down.

Obviously, then, you could have a nursing home facility fully licensed. You could then have a health-related facility fully licensed. You could then have a custodial area fully licensed.

At least you would break the log jam and move the people out of the hospital. You have made it so restricted that we cannot get the system flowing. We cannot get the people moving. This is the tragedy of the situation.

Mr. CONABLE. In your statement you said something about the non-profits costing more than the profits. That does not make much sense, right on the face of it. What do they do to run their costs up? What is the problem there?

You are connected with both nonprofit and profitmaking nursing homes?

Mr. RICHARDSON. That is right. At this particular point I am trying very hard to have one nonprofit try to become very cost conscious, and so far I am beginning to be successful.

But what happens is that you have a lot of the nonprofit people that have just taken this very easy way out, that the Government said they would pay all costs, regardless of cost, and so I can very easily think of 10 different people that you could easily hire in a nonprofit organization. You have a business manager, and an accountant, and this person, and that person, and the Government has said, "We will pay all costs."

Mr. CONABLE. That is only true with respect to the public programs, though.

Mr. RICHARDSON. Well, but the point is that the minute the Government has said this, it drives the entire costs up to the private sector.

When you start to drive up the costs to the private sector, then you have contributed at that point to the major contributing increase in cost of living, which is health care cost, and this is repeatedly appearing in the Government statistical data.

Or, in other words, if I could just maybe back-track here, to a letter I wrote in 1966, before medicare became available to the nursing homes, and this is something I have been working on now for 3 years, and I would like to put it into the record. I was advised to write to the district manager of social security on how I could implement title XVIII and title XIX simultaneously, at a fraction of the cost.

I will just read the letter as I wrote it.

Concerning our telephone conversation this morning, I will outline a few of my thoughts regarding the Medicare program which starts January 1, 1967 for Nursing Homes.

As long as titles XVIII and XIX are amendments to the original Social Security Act, it would seem as though Medicare and Medicaid could be tied together in New York State. In order to establish a reimbursement rate for Nursing Homes immediately, it might seem advisable to accept the rate that has been established for Medicaid—

Mr. CONABLE. That is on a contractual basis, is it not?

Mr. RICHARDSON. Well, I would just say that medicaid is cost-accounted by each State health department where they have a medicaid program, if you have a medicaid rate which is already determined, and in New York State every single facility has had one determined.

I will go back and pick up that sentence.

In order to establish a reimbursement rate for Nursing Homes immediately, it might seem advisable to accept the rate that has been established for Medicaid as the minimum rate which could apply to Medicare. In doing this it would allow Nursing Homes to accept patients immediately for Medicare without going through the difficulties of a cost accounting analysis, and the Nursing Homes would know their minimum payment now and this could avoid the reluctance of the Nursing Home Operators in signing the contract that they have received from Mr. Godfrey. (Social Security Administration). The information available from Blue Cross and the Hamilton Life Insurance Company and the unanswered questions at this time proves the fact that this agreement with Mr. Godfrey regarding the signing of this contract, leaves the Nursing Home operators in a dilemma. Any Nursing Home at a later date that wants to run their cost analysis when more concrete information is known from the Social Security Administration and the fiscal intermediary, and when the reimbursement formula is no longer subject to weekly changes or directions, could do so. Later Nursing Homes would be able to cost account in a leisurely manner and a more thorough and accurate cost figure could be obtained.

New York State has one of the first Medicaid programs in the country and as long as these rates are acceptable to the Federal Government, it seems as though this would be a legitimate way to start New York State into the Medicare program without any discontinuity in medical services and allow us to take care of all the people that are expecting to be covered by Medicare programs on January 1st (if they qualify).

If this type of approach is used by the Social Security Administration it would have complete jurisdiction over which facilities would be used for Medicare patients through the process of certification. Also it would allow the Nursing Homes that were certified to make a more general decision as to whether or not it is worth the additional income to go through the extra costs in order to do all of the cost accounting which now is apparently going to be required.

I would be very glad to discuss this in detail as to how it could be satisfactorily handled.

This letter went from the local Social Security Administration to the regional office in New York City, and then I think passed down here to Washington somewhere, and in the 2 or 3 years we have been trying to get an answer, we cannot get one.

Mr. BURKE. Have you read the entire letter?

Mr. RICHARDSON. That is the letter, yes.

Mr. BURKE. The staff will see to it that this is brought to the attention of the Department of Health, Education, and Welfare, and we will try to get an answer.

(The letter referred to follows:)

DECEMBER 22, 1966.

J. M. TOMAINO

*District Manager, Social Security Administration, 107 Clinton Avenue North,
Rochester, New York*

DEAR MR. TOMAINO: Concerning our telephone conversation this morning, I will outline a few of my thoughts regarding the Medicare program which starts January 1, 1967 for Nursing Homes.

As long as titles XVIII and XIX are amendments to the original Social Security Act, it would seem as though Medicare and Medicaid could be tied together in New York State. In order to establish a reimbursement rate for Nursing Homes immediately, it might seem advisable to accept the rate that has been established for medicaid as the minimum rate which could apply to medicare. In doing this it would allow Nursing Homes to accept patients immediately for Medicare without going through the difficulties of a cost accounting analysis,

and the Nursing Homes would know their minimum payment now and this could avoid the reluctance of the Nursing Home Operators in signing the contract that they have received from Mr. Godfrey. (Social Security Administration). The information available from Blue Cross and the Hamilton Life Insurance Company and the unanswered questions at this time proves the fact that this agreement with Mr. Godfrey regarding the signing of this contract, leaves the Nursing Home operators in a dilemma. Any Nursing Home at a later date that wants to run their cost analysis when more concrete information is known from the Social Security Administration and the fiscal intermediary, and when the reimbursement formula is no longer subject to weekly changes or directions, could do so. Later Nursing Homes would be able to cost account in a leisurely manner and a more thorough and accurate cost figure could be obtained.

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I would be very glad to discuss this in detail as to how it could be satisfactorily handled.

Sincerely yours,

MORRIS E. RICHARDSON.

Mr. RICHARDSON. What I am saying here, quickly, if I just may depart from the statement, is if medicare covers a patient for 100 days in a nursing home, and if the average length of stay in any nursing home facility is 3 years, which it is, then 100 compared to 3 years, which is 1,000 days, automatically means that the maximum number of patients in any nursing home facility at any one given time statistically is no more than 10 percent.

Now let me develop this with you all.

If they come into an area that has 40 nursing homes, and they only certify five, and these five nursing homes have 100 beds, these nursing homes are not empty. There is not 100 percent of the five nursing home beds available. There is only probably 10 percent, statistically, at any one given time.

Do I make my point?

You see, the beds have not been allowed to come into the medicare system, and the hospitals are blocked up.

I mean this is critical, you see. The situation has stopped functioning. We have stopped delivering medical care to an awful lot of people whom we told they were legally entitled to it.

Mr. CONABLE. And if you do come into the systems, the conditions of participation are such that it costs all your nonmedicare patients very substantially in order for you to come into the system.

Mr. RICHARDSON. Right, it raises the overall level of health care to the entire society.

Mr. CONABLE. Of which 90 percent are not going to be medicare patients, even if you come into the system. Is that right?

Mr. RICHARDSON. Right, in a nursing home, particularly, you see.

Mr. BURKE. There was an article in a great newspaper up in my district, the Quincy Patriot-Ledger, just last week referring to this problem. In fact, in the article was mentioned the amount of beds they had a year ago, and the amount of beds they had now available, and it

seems to indicate that there are less beds available now in the town of Stoughton, Mass., I believe it was, than there were a year ago. I believe there was about an 8- or 10-percent drop in the amount of beds available.

Now, I don't know whether it was caused by a lack of certification of these places, or because of the withdrawal on the part of some of these nursing homes from the medicare program.

Some of them I guess had withdrawn, but nevertheless it indicates that this is a subject matter that should be looked into by the Department of Health, Education, and Welfare, and particularly with relation to this legislation that we are writing now, and, as you have very graphically pointed out here today. Problems do exist.

Mr. RICHARDSON. I don't believe, you see, these problems exist.

Mr. BURKE. Do you find many nursing homes that have been certified in your area of New York that have withdrawn from the medicare program?

Mr. RICHARDSON. We have not added any new ones, and they are simply encumbered with so much medical recordkeeping and cost accounting that the decision that some of them are coming to is, "Why should I raise the price to all of the private paying section of the economy for trying to handle a maximum number of 10 percent patient load for the Federal Government under medicare, and it is actually easier."

The tragedy of the situation now, and I am talking to you very frankly, is that if you went into the hospital, and you were medicaid-eligible, you will find that you have your choice of any nursing home, and medical facilities are available to you; but yet, if you go in as a medicare, you are definitely discriminated against, and this is the truth.

This is a very surprising administrative result of a program. I mean this is a known fact.

Mr. CONABLE. I have one last question, Mr. Chairman.

What is your cost for a good medicare bed? You mentioned in your statement that the costs run all the way from \$13 to \$28.

Mr. RICHARDSON. I would like to answer this in two different ways, if I could.

Five years ago, when we built our original facility, woodframe construction was acceptable. It is a one-story building, and everybody is within 50 feet of an exit door. So wood frame was approved. It was, shall we say, \$5,000 per bed to build that facility.

We are reimbursed under medicaid \$13 a day. We have licensed RNs on 24 hours a day, and I feel we are giving very good care.

Now, the new facility that I have just opened up less than 3 weeks ago, all fire-resistant, and structurally meets all the requirements for medicare, I expect will price out at about \$16 a day, and it is about three times the mortgaging on it, due to the structural requirements of medicare. But my people are still within 50 feet of any exit door.

Now, what we find here is that, if an operator wants to try to provide his room to the general public as economically as possible, then medicaid and medicare can come into this facility for no more than \$15 or \$16 a day. And I intend to start my processing now for medicare.

But the critical point here is that, if I find it starts to drive up my overhead costs exceptionally high, then I am going to back off on it. This is what many, many nursing home operators have found.

Now, if you don't pay any attention to cost, and you don't watch this thing very carefully, then the nonprofit people are spending as high as \$20,000 to \$30,000 per bed, and I only spent \$11,000, but structurally I met all the medicare requirements.

Mr. BURKE. Mr. Corman?

Mr. CORMAN. Yes, thank you, Mr. Chairman.

Mr. RICHARDSON. I am sorry. I don't mean to lecture, but you have to answer those in depth, because this is tricky.

Mr. BURKE. You have done an excellent job.

Mr. CORMAN. You have been tremendously helpful, because it does seem to me that there is a great potential here for relieving the pressure on hospitals and to get many, many more people medical care than are getting it now, by adequately utilizing the facilities we have.

I don't know that I have had any more complaints from anyone than I have from the extended care facility people and the intermediate care people.

They also point out that in California there is a substantial difference in trying to give treatment to medicare and medicaid patients.

Let me ask if you have had any problem with there being a retroactive allowance.

Mr. RICHARDSON. I have not specifically had this problem.

Mr. CORMAN. Are you aware of anybody in New York having this problem?

Mr. RICHARDSON. Absolutely. As a matter of fact, I have been scrapping in the last few months for the nonprofit facility I am in, where we are \$17,000 behind on retroactive medicaid patients, because they arbitrarily will not establish a rate for a nonprofit.

I might point out not only am I on this board of directors but just a week ago I have been given the responsibility of running a large nonprofit economically at the same time I am operating a proprietary, and the regulatory people have hold me I am in a definite conflict of interest and cannot contribute to the nonprofit.

This has been done in letter form. I think it is intriguing because the same people that wrote this letter criticized my wife and her partner for maintaining this other operation at \$13 a day. They said, "Why don't you raise your costs?" My wife just sat there and said, "I am sorry. We sort of lose money when we raise costs."

This is intriguing.

Mr. CORMAN. Let me ask this.

Mr. RICHARDSON. Fire all questions, please, because this is what is good about this.

Mr. CORMAN. You have an operation where, let us say, you have 100 beds, and 10 of them are medicare beds, but there is going to be a substantial amount of administrative costs because of those 10 medicare beds.

Do I understand correctly that you are not permitted to amortize that extra cost just over the 10 beds, but you have to amortize it over the 100 beds?

Mr. RICHARDSON. I would have to pay for all the costs, and I will only be reimbursed for the 10, or the percentage of occupancy that that facility had for medicare patients, versus medicaid and private patients.

This drives up the cost to the private health care sector.

Mr. BURKE. Will you yield at that point?

Mr. CORMAN. I yield.

Mr. BURKE. Where you have an allotment, say of 10 beds, and only eight of them are occupied, are you reimbursed for the other two that are not occupied, if you have 10 beds set aside for medicare patients?

There was a charge made last week by one of the officials of one of the big hospitals that the cost of medicare was being skyrocketed because the medicare program is paying for beds that are not being used.

Mr. RICHARDSON. Well, this should not really happen, because all facilities should really be operating today at 100 percent occupancy. I don't see how that really applies.

Mr. BURKE. If it happened, does the program pay for those unoccupied beds?

Mr. RICHARDSON. If it happened, I am darn sure a hospital would get paid. They get paid I think total cost if the occupancy does not drop below 90 percent.

Mr. BURKE. What kind of a contract does a hospital enter into with a nursing home? Do they enter into a contract to set aside a certain amount of beds for that hospital?

Mr. RICHARDSON. They might, in one sense of the word, but I doubt that there is any real firm contracting done.

I have been asked to make available to the Strong Memorial Hospital, which is the University of Rochester, eight beds at my new facility, which I am doing, and I am turning these beds over to them to technically administer, and as long as they keep their patients moving, they have got eight beds.

I might point out in this industry that statistically every nursing home or extended care facility loads up. In other words, the first year of operation I may have 80 admissions, and 40 discharges, and then I find that I have locked in 20 beds. The second year I may admit 40 patients and discharge 20, and I have locked in 10 more, you see.

In other words, you get people in there that you cannot get out the door, so you find out that once you have been in operation for 5 years, a 40-bed nursing home over an entire year, 1968, will only admit one patient a month, and this carries over into the big facilities that even have 200 beds. They only admit about 40 people a year.

You see, if we cannot make every bed available in the country, by definition, to medicare, we cannot begin to move the people out of the hospitals, just by definition alone.

Mr. BURKE. Mr. Corman.

Mr. CORMAN. As I understand it, medicare patients, to have eligibility for extended care or intermediate care, must physically show signs of improvement, or medically hold out some promise for improvement. When they slip into that domiciliary category, where they are just at holding level, or actually expiring, they are not eligible. Is that the case?

Mr. RICHARDSON. That is absolutely correct, for medicare, but that is not the case for medicaid. They have their choice at any time to any facility, but you have denied it to the medicare recipient, and this is the individual that has been gainfully employed, made his social security for the last 20 or 30 years, who honestly figures he has a

benefit, but administratively it is being denied repeatedly to this individual.

Mr. CORMAN. Do I understand correctly that these decisions are frequently made by nonmedical people?

Mr. RICHARDSON. You are very, very correct.

What you are finding now, and I wish the Aetna people had not left, is that the fiscal intermediaries are attempting to pass judgment on a filled out piece of paper as to whether or not a patient belongs in a hospital or in a nursing home, or should go home.

If you wanted to get into examples, here, we could do it very easily.

A form might point out that a patient had a stroke, and the husband was living at home. The clerical staff immediately checks. This patient may go home.

But they don't know the situation with the husband, and technically this man may be blind. This man is home, yes, but he may not be in any way capable of helping his wife out.

These are the big inequities now that are coming into this by allowing nonmedical people to make a lot of medical judgments, and right in your very first paragraph of the law in 1966 you stated that nothing in this act will be construed that any medical decisions will be made in this program, and yet, now, you find that certainly recuperation, needing of an extended care or an intensive care, has put you people into deciding the medical condition that people will be eligible, and this was certainly not your original intent, and this is really upsetting a very large part of the populace, because we have had people that have made the decision to come to our nursing home, and forfeit medicare, because this is where they preferred to go, and this is why I emphasize this in my little write-up.

The medicare patient has lost his freedom of choice as to where he would like to recover. The medicare patient—don't let me misspeak. The medicare patient has lost his freedom on where he would like to go.

And the medicaid patient has everything, at the moment, working in his favor.

I would like to see them both have their freedom of choice. I am not saying take anything away from the medicaid patient. It is the people's right to have medical care. It is our responsibility to revamp the system and deliver it, and I am very, very emphatic when I say they need a clean bed, they need good food, they need tender loving care, and this business of putting them in the Hotel Americana is going to break us. We don't have the resources to do it, whether it be \$10 billion or \$20 billion.

What I am really saying, and let me dig into this further, if I may, is that we probably need about five levels of differentiated care, and one of them may even come all the way down to \$5 a day, in one area, custodial. Health related might come in at \$10. Nursing home might come in at \$15. Intensive care unit in a nursing home or extended care facility, might price out at \$20.

What has happened in the program is that they are demanding that everybody go into the highest cost level of care, which is just ridiculous.

I am not a lawyer, but this is almost a legal thing which has to be resolved first.

Just simply say we will only spend for these people the amount of money that we feel they need. But you do have to inject back into this medical system the fact that the patient has the right to go out and shop around, and when he starts to get cost conscious, you will then see your prices come down for medical care. It is absolutely obvious.

Mr. CORMAN. All I can say, sir, is that if it is any comfort to you, the people in California appear to be having precisely the same problems you are, and the only difference I see is that your costs per bed are substantially lower than the costs in California.

Mr. RICHARDSON. I have talked to people from Kaiser up at the Harvard Medical School and Harvard and Tufts and Massachusetts General are sending a crew out to Kaiser almost every 3 or 4 months to study this system, and they do have a 30 percent reduction in cost.

Mr. CORMAN. I was referring to the private extended care facilities. Your price on extended care is considerably lower, but again they tell me that a big chunk of that cost of extended care goes not to nurses and not to medical people, but to accountants.

Mr. RICHARDSON. This is exactly right. Where the big chunk has been added to the overall cost, the patient is benefitting absolutely zero. It is not a patient-oriented cost, and this is critical.

Mr. BURKE. Thank you very much.

There being no further questions, this concludes our hearing for the day, and the committee stands adjourned, to meet at 10 a.m. tomorrow.

Mr. RICHARDSON. I thank you very much.

(Whereupon, at 4:15 p.m., the committee adjourned, to reconvene at 10 a.m., Friday, Nov. 7, 1969.)

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